REPORT OF EXAMINATION

OF

UNITED HEALTHCARE OF ALABAMA, INC.

AS OF

DECEMBER 31, 2001

TABLE OF CONTENTS

STATE OF ALABAMA
COUNTY OF JEFFERSON

James L. Hattaway, III, being first duly sworn, upon his oath deposes and says:

THAT he is an examiner appointed by the Commissioner of Insurance for the State of Alabama;

THAT an examination was made of the affairs and financial condition of UNITED HEALTHCARE OF ALABAMA, INC., for the period from January 1, 2000 through December 31, 2001;

THAT the following 99 pages constitute the report to the Commissioner of Insurance of the State of Alabama; and

THAT the statements, exhibits and data therein contained are true and correct to the best of his knowledge and belief.

James L. Hattaway, III, CFE
(Examiner-in-Charge)

Subscribed and sworn to before the undersigned authority this 17th day of February 2004.

(Signature of Notary Public)

Mary Anne Flynn, Notary Public
(Print Name of Notary Public)

in and for the State of Alabama.

NOTARY PUBLIC STATE OF ALABAMA AT LARGE
MY COMMISSION EXPIRES: Aug 30, 2007
BONDED THRU NOTARY PUBLIC UNDERWRITERS

BOB RILEY
GOVERNOR

STATE OF ALABAMA
DEPARTMENT OF INSURANCE
201 MONROE STREET, SUITE 1700
POST OFFICE BOX 303351
MONTGOMERY, ALABAMA 36130-3351
TELEPHONE: (334) 269-3550
FACSIMILE: (334) 241-4192
INTERNET: www.aldoi.org

WALTER A. BELL
COMMISSIONER
DEPUTY COMMISSIONER
D. DAVID PARSONS
JAMES R. (JOHNNY) JOHNSON
CHIEF EXAMINER
RICHARD L. FORD
STATE FIRE MARSHAL
JOHN S. ROBISON
GENERAL COUNSEL
MICHAEL A. BOWNES
RECEIVER
DENISE B. AZAR
PRODUCER LICENSING MANAGER
JIMMY W. GUNN

Birmingham, Alabama
February 13, 2004

Honorable Walter A. Bell
Commissioner of Insurance
State of Alabama Department of Insurance
201 Monroe Street, Suite 1700
Montgomery, Alabama 36130-3351

Dear Commissioner Bell:

Pursuant to your instructions and in compliance with the statutory requirements of the State of Alabama and the resolutions of the National Association of Insurance Commissioners, an examination as of December 31, 2001, has been made of the affairs, financial condition, and market conduct of **United HealthCare of Alabama, Inc.** at its home office located at 3700 Colonnade Parkway, Birmingham, Alabama 35243. The report of examination is submitted herewith.

Where the description "Company" appears herein, without qualification, it will be understood to indicate United HealthCare of Alabama, Inc.

SCOPE OF EXAMINATION

The Company was last examined for the three-year period ended December 31, 1999. The current examination covers the two-year period from January 1, 2000 through December 31, 2001, and was conducted by examiners representing the State of Alabama Department of Insurance. Where deemed appropriate, transactions subsequent to December 31, 2001, were reviewed.

The Company was to be examined in accordance with the statutory requirements of the Alabama Insurance Code and the regulations and bulletins of the Alabama Department of Insurance; in accordance with the applicable guidelines and procedures promulgated by the National Association of Insurance Commissioners (NAIC); and in accordance with generally accepted examination standards.

The discussion of assets and liabilities contained in this report has been confined to those items which indicated a violation of the Alabama Insurance Code, the Insurance Department's rules and regulations, or which were deemed to require comments and/or recommendations.

A signed certificate of representation was obtained during the course of the examination. In this certificate, management attests to have valid title to all assets and to the nonexistence of unrecorded liabilities as of December 31, 2001. A signed letter of representation was also obtained at the conclusion of the examination whereby management represented that, through the date of this examination report, complete disclosure was made to the examiners regarding asset and liability valuation, financial position of the Company, and contingent liabilities.

The Company's financial statements, as reported by the Company in its filed Annual Statements, are included on pages 97-99 of this report.

The market conduct portion of the examination consisted of a review of the Company's territory, plan of operation, policy forms, rates and underwriting practices, advertising and marketing, treatment of policyholders and claimants, and compliance with agents' licensing requirements.

ORGANIZATION AND HISTORY

The information contained in this section of the examination report was excerpted from prior examination reports and updated as appropriate.

The Company was founded in April 1985, as a joint venture between the Medical Advancement Foundation, an affiliate of the University of Alabama Health Sciences Foundation, and certain individual businessmen. Under the laws of the state of Alabama, the Company was incorporated on July 16, 1985, as "Complete Health, Inc.," a for-profit health maintenance organization (HMO).

On November 15, 1989, with the approval of the Alabama Department of Insurance, the shareholders of the Company transferred their stock to United HealthCare South, Inc. (formerly known as Complete Health Services, Inc.), thereby making the Company a wholly-owned subsidiary of United HealthCare South, Inc. (UHC-South).

A change in the ultimate control of the Company occurred in May of 1994, when UHC-South, the parent, merged with United HealthCare Corporation (UHCorp). On April 30, 1996, United HealthCare Services, Inc. (UHS), an HMO management corporation and a wholly-owned subsidiary of UHCorp, purchased UHC-South for its net book value from UHCorp. UHS became the sole shareholder of UHC-South.

Effective May 1, 1996, the name of the Company was changed from "Complete Health, Inc." to the current "United HealthCare of Alabama, Inc." Also on that date, the Company's wholly-owned subsidiary, Complete Health of Alabama, Inc., changed its name to "United HealthCare of Alabama-FQ, Inc." (UHC AL-FQ).

On January 2, 1998, UHC-South merged into UHS, whereby UHS became the sole shareholder of the Company.

On December 31, 1998, UHC AL-FQ merged into the Company, with the Company being the surviving entity. Since the Company and UHC AL-FQ were under common control, the transaction was accounted for as a "pooling of interest."

As of June 30, 2000, UHS contributed its common stock of the Company to United HealthCare, Inc.

At December 31, 2001, the Company's Annual Statement reflected outstanding capital stock totaling $121,978, which consisted of 927,074 shares of common stock of $.11 par value and 2,000,000 shares of $.01 par value preferred stock. In addition to the capital stock, the Company reported $17,561,870 of gross paid in and contributed surplus, $41,307,833 of unassigned funds (surplus) and $(56,250) of treasury stock.

MANAGEMENT AND CONTROL

Stockholders

As of December 31, 2001, United HealthCare, Inc. owned 927,074 shares of the common voting stock of the Company, representing 100% of the common voting stock of the Company, issued and outstanding. Fifteen thousand shares were held as treasury stock.

The Company also had 2,000,000 shares of preferred stock issued and outstanding, all of which were owned by UnitedHealthcare, Inc.

Board of Directors

The By-Laws of the Company provided that its business and affairs shall be managed by the Board of Directors having no less than five and no greater than 17 directors.

On March 3, 2001, the following directors were elected in a written action in lieu of the annual meeting of the sole shareholder, and were serving at the examination date:

Name/Residence	Principal Occupation
Brian K. Beutner Minnetonka, Minnesota	Secretary United HealthCare Corporation
William A. Munsell Edina, Minnesota	Chief Administrative Officer United HealthCare Corporation
Charles C. Pitts Birmingham, Alabama	Chief Executive Officer United HealthCare Corporation

Robert J. Sheehy Edna, Minnesota	Vice President, COO United HealthCare Corporation
John A. Wickens Brentwood, Tennessee	Senior Vice President United HealthCare Corporation

Officers

Officers elected by a written action in lieu of an annual meeting of the Board of Directors, and serving at December 31, 2001, were as follows:

Officers	Title
Charles C. Pitts	Chairman and Chief Executive Officer
Jack Wickens	President
William A. Munsell	Vice President and Assistant Treasurer
Gary C. Baker	Chief Financial Officer
Allan J. Weiss	Treasurer
David J. Lubben	Assistant Secretary
Diane L. Flottemesch	Vice President - Taxes
John W. Kelly	Vice President - Tax Services
James W. Fielder, Jr.	Chief Operating Officer
Larry B. Amacker, M.D.	Senior Medical Director
Rhonda R. Bagby	Vice President - Finance and Network Development
Daniel J. McAthie	Vice President - Finance and Assistant Treasurer

Committees

The Company's Board of Directors, through the quality improvement program, appointed the members of the Executive Oversight Committee (EOC), with the Chief Executive Officer as the chairperson.

It was determined that the Company appointed individuals other than members of the Board of Directors to serve on the Executive Oversight Committee, which is in violation with ALA. CODE § 10-2B-8.25 (1975), which states that:

"Unless the articles of incorporation or bylaws provide otherwise, a Board of Directors may create one or more committees and appoint members of the

Board of Directors to serve on them. Each committee may have one or more members, who serve at the pleasure of the Board of Directors."

The EOC then appointed a variety of committees to review and facilitate health maintenance organization operations within the holding company system. Below is a listing of the Company's committees and the positions that comprise them:

- Executive Oversight Committee:
  - CEO (Chair)
  - Sr. Medical Director
  - VP of Health Services
  - Manager of Medicare
  - Director of Physician Services
  - VP of Sales
  - VP of Operations
  - Manager of Provider Relations
  - Compliance Officer
  - Director of Quality Improvement (QI)
- Alabama Peer Review Committee
  - Medical Director
  - Permanent Care Physician (PCP) Members (3) (1 of the PCP or Specialists will be the chair)
  - Specialist Physician Members (3)
  - Compliance Officer
  - Provider Information Management
  - Manager of Provider Relations
  - Director of Quality Improvement
- North Alabama Credentialing Committee
  - Medical Director
  - PCP Physician Members (3) (1 of the PCP or Specialists will be the chair)
  - Specialist Physician Members (3)
  - Compliance Officer
  - Manager of Provider Relations
  - Director of Quality Improvement
- Gulf Coast Credentialing Committee
  - Medical Director
  - PCP Physician Members (3) (1 of the PCP or Specialists will be the chair)

- Specialist Physician Members (3)
- Compliance Officer
- Manager of Provider Relations

- Health Services Management Committee
  - CEO
  - VP of Health Services
  - Compliance Officer
  - Medicare Product Manager
  - Medical Director
  - VP of Sales
  - VP of Operations
  - Director of Quality Improvement
  - Participating Plan Physicians (7)
- Service Management Committee
  - VP of Sales
  - VP of Operations
  - Compliance Officer
  - Director of Quality Improvement
  - Alabama Business Unit manager
  - Manager of Provider Relations
  - Consumer Affairs Representative
  - Personal Service Specialist (PSS) Manager
  - VP of Health Services
  - Continuous Quality Improvement (CQI) Manager
  - Medicare product Manager
- Policy and Procedure Committee
  - VP of Sales
  - VP of Operations
  - Compliance Officer
  - Director of Provider Information Management
  - Director of Quality Improvement
  - General Manager of Claims and Customer Service
  - Alabama Business Unit manager
  - Manager of Provider Relations
  - Claims/Cost Containment Manager
  - Manager of Case Management
  - Supervisor of Compliance and Consumer Affairs
  - Medicare Product Manager

- Compliance Committee
  - CEO
  - VP of Operations
  - Director of Physicians Services
  - VP Sales & Marketing
  - VP Health Services
  - Director of QI
  - VP Government Programs
  - Compliance Officer / Director of Provider Information Management
  - Director of Finance
  - Manager Human Resources (HR)
  - Manager Provider Relations (PR)
  - Manager Information System and Technology (IS&T)
  - Director Claims Operations
  - Senior Medical Director
- Delegated Activities Committee
  - VP of Sales
  - VP of Operations
  - Compliance Officer
  - Director of Provider Information Management
  - Director of QI
  - Director of Claims and Customer Service
  - Alabama Businesses Unit Manager
  - Manager of Provider Relations
  - Claims/Cost Containment Manager
  - Manager of Case Management
  - Supervisor of Compliance and Consumer Affairs
  - Medicare Product Manager
  - Medical Director (Chair)
- Commercial Formal Complaint Committee
  - Formal Complaint Committee Supervisor (Chair)
  - Medical Director
  - Customer Service/Claims Manager or designee
  - Compliance Officer
  - Marketing VP of Operations
- Medicare Consumer Affairs Review Committee
  - Consumer Affairs Supervisor
  - Medical Director
  - Customer Services/Claims Manager or designee

- Medical Management Manager or designee
- Director of Utilization Management or designee
- Medicare Product Manager or designee
- Compliance Officer or designee

The committees listed above reported either directly or through committees to the Executive Oversight Committee (EOC).

The review of corporate minutes indicated the adoption and approval of numerous committee reports, which appeared to accurately reflect the recommendations and actions of the various committees.

Conflict of Interest

The Company had an established procedure for the disclosure of any outside interests, memberships, associations and/or affiliations an individual may have as a director, officer and/or key management personnel. The Conflict of Interest Policy was established in the By-Laws. On March 15, 1997, an updated version of the existing policy was adopted by the Board of Directors. Questionnaires were completed annually by all relevant individuals, then reviewed and approved by the Board of Directors. A review of the statements signed during the examination period did not disclose any conflicts.

It was noted that all of the directors and some of the officers served as an officer and/or director of various entities affiliated with the Company's parent, UnitedHealthcare, Inc.

CORPORATE RECORDS

The Company's Certificate of Incorporation and By-Laws (restated May 26, 1998) were inspected and found to provide for the operation of the Company in accordance with usual corporate practices.

Records of the meetings and actions of the Stockholder, Board of Directors and various committees, since December 31, 1999, were reviewed.

There were no changes to the Company's Certificate of Incorporation or By-Laws during the two-year examination period.

HOLDING COMPANY AND AFFILIATE MATTERS

Holding Company – Data Ownership

The Information Technology Services Agreement, as of June 1, 1996, between United Healthcare Services, Inc., an affiliate of the Company, and Unysis Corporation, Article 16.01 states "The UHS Data is and shall remain the property of UHS and its Affiliates." This agreement gives ownership of the "UHS Data" to UHS and its affiliates, but it does not give sole ownership of the Company's data to the Company.

The Information Technology Services Agreement, as of November 1, 1995, between Metra Health, now known as United HealthCare Insurance Company, an affiliate of the Company, and Integrated Systems Solutions Corporation Article 16.01 states "The Metra Health Data is and shall remain the property of Metra Health and its Affiliates." This agreement gives ownership of the "Metra Health Data" to Metra Health and its affiliates, but it does not give ownership of the Company's data to the Company.

Holding Company Registration

The Company was not subject to *the Alabama Insurance Holding Company Regulatory Act*, as defined in ALA. CODE § 27-29-1 (1975), except as expressly required by other statutes and regulations. Generally, HMOs are subject to regulation in regard to changes in control, but are not subject to the continuing holding company reporting requirements that apply to insurance companies.

The Company has been a member of a holding company system since 1989, when the former Complete Health Services, Inc. acquired it.

United HealthCare Services (UHS) was the sole shareholder of the Company until June 30, 2000, when pursuant to regulatory approval granted on June 15, 2000 by the Alabama Department of Insurance, United HealthCare Services, Inc. transferred its ownership interest in the Company to United Healthcare, Inc., a Delaware general business corporation and a wholly owned subsidiary of United HealthCare Services, Inc. United HealthCare Services, Inc. owns, directly and indirectly, numerous health care companies nationwide. The ultimate controlling entity of the general business holding company system is UnitedHealth Group Incorporated (formerly known as United HealthCare

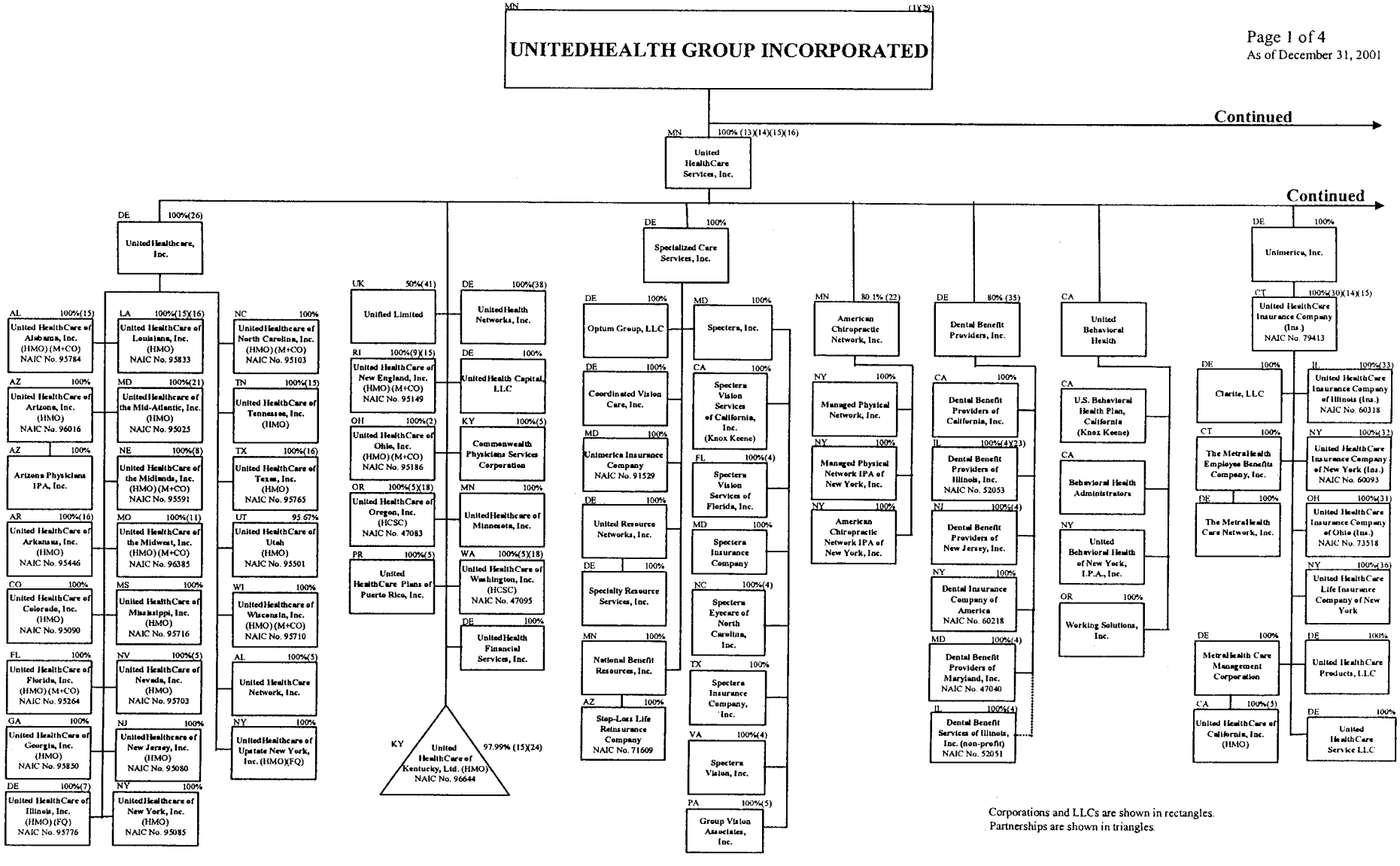
Corporation). UnitedHealth Group has several segments with companies engaged in different kinds of business and does not regard its primary business as health care or life and health insurance. UnitedHealth Group, through its family of companies, has four major businesses, according to Associate General Counsel:

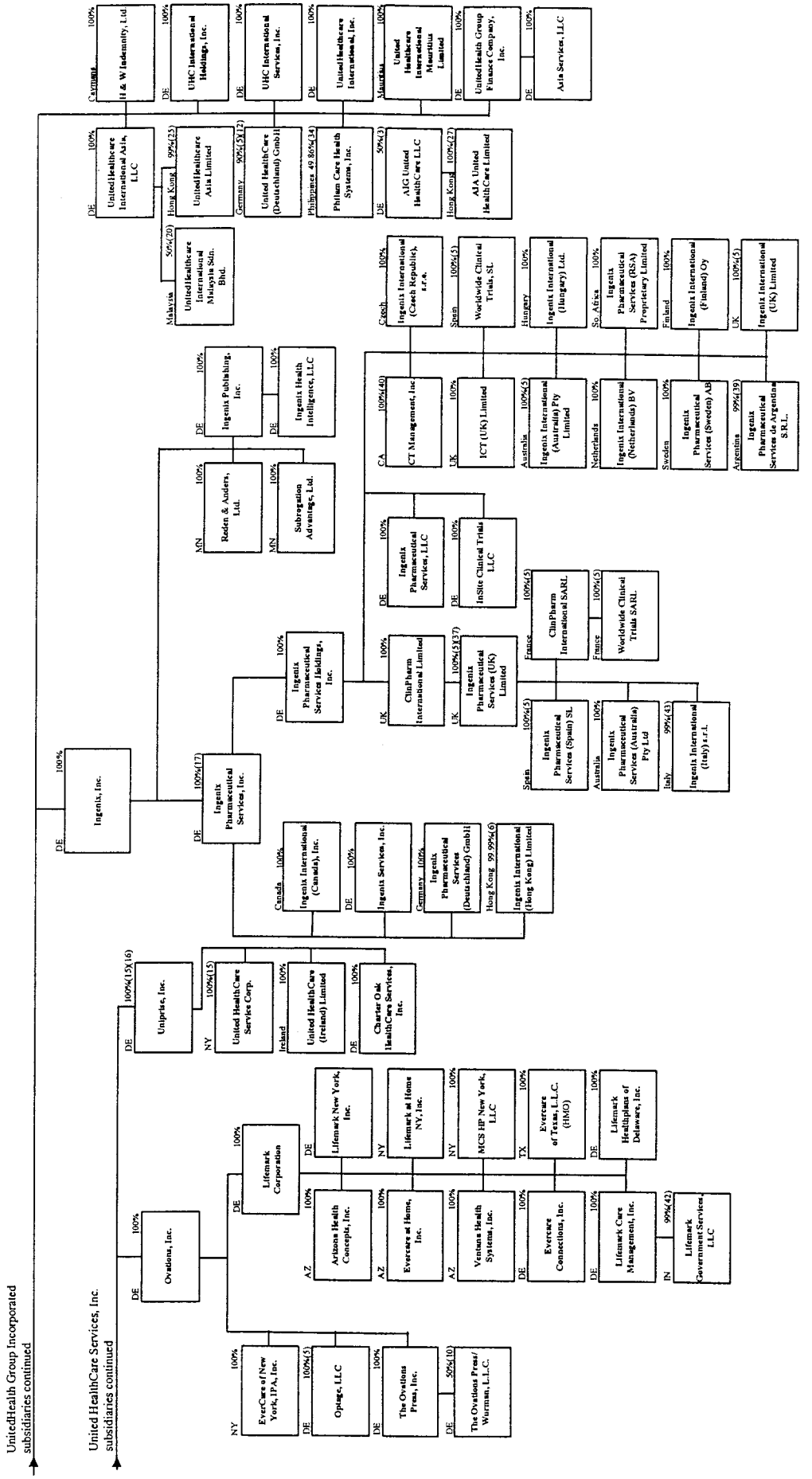
"Uniprise is the nation's leading provider of benefit delivery and service solutions for large, multi-location employers and insurers. Health Care Services includes the businesses of UnitedHealthcare [health benefit plans and services for small and mid-sized employers], AmeriChoice[network based benefit offerings and personal care management programs for individuals in state-sponsored health care programs, like Medicaid], and Ovations [variety of products and services for the health and well-being needs of individuals age 50 and older]. Specialized Care Services operates [numerous] freestanding businesses, each of which has product and services capabilities dedicated to serving a unique area of health care. Ingenix is an international leader in the field of health care data analysis and application."

A detailed description of the various corporate changes since the Company's inception may be found under the heading "ORGANIZATION AND HISTORY," in this report.

Organizational Chart

The following chart presents the identities of and inter-relationships among all affiliated persons within the Insurance Holding Company System at December 31, 2001.


MN (1)(29)
UNITEDHEALTH GROUP INCORPORATED
Continued
MN 100% (13)(14)(15)(16)
United HealthCare Services, Inc.
Continued
DE 100%(26)
United Healthcare, Inc.
AL 100%(15)
United HealthCare of Alabama, Inc. (HMO) (M+CO) NAIC No. 95784
AZ 100%
United HealthCare of Arizona, Inc. (HMO) NAIC No. 96016
AZ 100%
Arizona Physicians IPA, Inc.
AR 100%(16)
United HealthCare of Arkansas, Inc. (HMO) NAIC No. 95446
CO 100%
United HealthCare of Colorado, Inc. (HMO) NAIC No. 95090
FL 100%
United HealthCare of Florida, Inc. (HMO) (M+CO) NAIC No. 95264
GA 100%
United HealthCare of Georgia, Inc. (HMO) NAIC No. 95850
DE 100%(7)
United HealthCare of Illinois, Inc. (HMO) (FQ) NAIC No. 95776
LA 100%(15)(16)
United HealthCare of Louisiana, Inc. (HMO) NAIC No. 95833
MD 100%(21)
United Healthcare of the Mid-Atlantic, Inc. (HMO) NAIC No. 95025
NE 100%(8)
United HealthCare of the Midlands, Inc. (HMO) (M+CO) NAIC No. 95591
MO 100%(11)
United HealthCare of the Midwest, Inc. (HMO) (M+CO) NAIC No. 96385
MS 100%
United HealthCare of Mississippi, Inc. (HMO) NAIC No. 95716
NV 100%(5)
United HealthCare of Nevada, Inc. (HMO) NAIC No. 95703
NJ 100%
United Healthcare of New Jersey, Inc. (HMO) NAIC No. 95080
NY 100%
United Healthcare of New York, Inc. (HMO) NAIC No. 95085
NC 100%
United Healthcare of North Carolina, Inc. (HMO) (M+CO) NAIC No. 95103
TN 100%(15)
United HealthCare of Tennessee, Inc. (HMO)
TX 100%(16)
United HealthCare of Texas, Inc. (HMO) NAIC No. 95765
UT 95.67%
United HealthCare of Utah (HMO) NAIC No. 95501
WI 100%
United Healthcare of Wisconsin, Inc. (HMO) (M+CO) NAIC No. 95710
AL 100%(5)
United HealthCare Network, Inc.
NY 100%
United Healthcare of Upstate New York, Inc. (HMO)(FQ)
UK 50%(41)
Unified Limited
RI 100%(9)(15)
United HealthCare of New England, Inc. (HMO) (M+CO) NAIC No. 95149
OH 100%(2)
United HealthCare of Ohio, Inc. (HMO) (M+CO) NAIC No. 95186
OR 100%(5)(18)
United HealthCare of Oregon, Inc. (HCSC) NAIC No. 47083
PR 100%(5)
United HealthCare Plans of Puerto Rico, Inc.
KY United HealthCare of Kentucky, Ltd. (HMO) NAIC No. 96644 97.99% (15)(24)
DE 100%(38)
United Health Networks, Inc.
DE 100%
United Health Capital, LLC
KY 100%(5)
Commonwealth Physicians Services Corporation
MN 100%
UnitedHealthcare of Minnesota, Inc.
WA 100%(5)(18)
United HealthCare of Washington, Inc. (HCSC) NAIC No. 47095
DE 100%
United Health Financial Services, Inc.
DE 100%
Specialized Care Services, Inc.
DE 100%
Optum Group, LLC
DE 100%
Coordinated Vision Care, Inc.
MD 100%
Unimerica Insurance Company NAIC No. 91529
DE 100%
United Resource Networks, Inc.
DE 100%
Specialty Resource Services, Inc.
MN 100%
National Benefit Resources, Inc.
AZ 100%
Stop-Loss Life Reinsurance Company NAIC No. 71609
MD 100%
Spectera, Inc.
CA 100%
Spectera Vision Services of California, Inc. (Knox Keene)
FL 100%(4)
Spectera Vision Services of Florida, Inc.
MD 100%
Spectera Insurance Company
NC 100%(4)
Spectera Eyecare of North Carolina, Inc.
TX 100%
Spectera Insurance Company, Inc.
VA 100%(4)
Spectera Vision, Inc.
PA 100%(5)
Group Vision Associates, Inc.
MN 80.1% (22)
American Chiropractic Network, Inc.
NY 100%
Managed Physical Network, Inc.
NY 100%
Managed Physical Network IPA of New York, Inc.
NY 100%
American Chiropractic Network IPA of New York, Inc.
DE 80% (35)
Dental Benefit Providers, Inc.
CA 100%
Dental Benefit Providers of California, Inc.
IL 100%(4)(23)
Dental Benefit Providers of Illinois, Inc. NAIC No. 52053
NJ 100%(4)
Dental Benefit Providers of New Jersey, Inc.
NY 100%
Dental Insurance Company of America NAIC No. 60218
MD 100%(4)
Dental Benefit Providers of Maryland, Inc. NAIC No. 47040
IL 100%(4)
Dental Benefit Services of Illinois, Inc. (non-profit) NAIC No. 52051
CA
United Behavioral Health
CA
U.S. Behavioral Health Plan, California (Knox Keene)
CA
Behavioral Health Administrators
NY
United Behavioral Health of New York, I.P.A., Inc.
OR 100%
Working Solutions, Inc.
DE 100%
Unimerica, Inc.
CT 100%(30)(14)(15)
United HealthCare Insurance Company (Ins.) NAIC No. 79413
DE 100%
Claritz, LLC
CT 100%
The MetraHealth Employee Benefits Company, Inc.
DE 100%
The MetraHealth Care Network, Inc.
DE 100%
MetraHealth Care Management Corporation
CA 100%(5)
United HealthCare of California, Inc. (HMO)
IL 100%(33)
United HealthCare Insurance Company of Illinois (Ins.) NAIC No. 60318
NY 100%(32)
United HealthCare Insurance Company of New York (Ins.) NAIC No. 60093
OH 100%(31)
United HealthCare Insurance Company of Ohio (Ins.) NAIC No. 73518
NY 100%(36)
United HealthCare Life Insurance Company of New York
DE 100%
United HealthCare Products, LLC
DE 100%
United HealthCare Service LLC
Corporations and LLCs are shown in rectangles.
Partnerships are shown in triangles.


UnitedHealth Group Incorporated subsidiaries continued
United HealthCare Services, Inc. subsidiaries continued
Cayman 100% H & W Indemnity, Ltd.
DE 100% UHC International Holdings, Inc.
DE 100% UHC International Services, Inc.
DE 100% United Healthcare International, Inc.
Mauritius 100% United Healthcare International Mauritius Limited
DE 100% United Health Group Finance Company, Inc.
DE 100% Axis Services, LLC
DE 100% United Healthcare International Asia, LLC
Hong Kong 99%(23) United Healthcare Asia Limited
Germany 90%(5)(12) United HealthCare (Deutschland) GmbH
Philippines 49.86%(34) Philam Care Health Systems, Inc.
DE 50%(3) AIG United HealthCare LLC
Hong Kong 100%(27) AIA United HealthCare Limited
Malaysia 50%(20) United Healthcare International Malaysia Sdn. Bhd.
Czech 100% Ingenix International (Czech Republic), s.r.o.
Spain 100%(5) Worldwide Clinical Trials, SL
Hungary 100% Ingenix International (Hungary) Ltd.
So Africa 100% Ingenix Pharmaceutical Services (RSA) Proprietary Limited
Finland 100% Ingenix International (Finland) Oy
UK 100%(5) Ingenix International (UK) Limited
DE 100% Ingenix Publishing, Inc.
DE 100% Ingenix Health Intelligence, LLC
MN 100% Reden & Anders, Ltd.
MN 100% Subrogation Advantage, Ltd.
CA 100%(40) CT Management, Inc
UK 100% ICT (UK) Limited
Australia 100%(2) Ingenix International (Australia) Pty Limited
Netherlands 100% Ingenix International (Netherlands) BV
Sweden 100% Ingenix Pharmaceutical Service (Sweden) AB
Argentina 99%(39) Ingenix Pharmaceutical Service de Argentina S.R.L.
DE 100% Ingenix, Inc.
DE 100%(17) Ingenix Pharmaceutical Services, Inc.
DE 100% Ingenix Pharmaceutical Service Holdings, Inc.
DE 100% Ingenix Pharmaceutical Services, LLC
DE 100% InSite Clinical Trials LLC
UK 100% ClinPharm International Limited
UK 100%(5)(37) Ingenix Pharmaceutical Services (UK) Limited
France 100%(5) ClinPharm International SARL
France 100%(5) Worldwide Clinical Trials SARL
Spain 100%(5) Ingenix Pharmaceutical Services (Spain) SL
Australia 100% Ingenix Pharmaceutical Services (Australia) Pty Ltd
Italy 99%(41) Ingenix International (Italy) s.r.l.
Canada 100% Ingenix International (Canada), Inc.
DE 100% Ingenix Services, Inc.
Germany 100% Ingenix Pharmaceutical Services (Deutschland) GmbH
Hong Kong 99.99%(6) Ingenix International (Hong Kong) Limited
DE 100%(15)(16) Uniprise, Inc.
NY 100%(15) United HealthCare Service Corp.
Ireland 100% United HealthCare (Ireland) Limited
DE 100% Charter Oak HealthCare Services, Inc.
DE 100% Ovations, Inc.
DE 100% Lifemark Corporation
AZ 100% Arizona Health Concepts, Inc.
AZ 100% Evercare at Home, Inc.
AZ 100% Ventura Health Systems, Inc.
DE 100% Evercare Connections, Inc.
DE 100% Lifemark Care Management, Inc.
IN 99%(42) Lifemark Government Services, LLC
DE 100% Lifemark New York, Inc.
NY 100% Lifemark at Home NY, Inc.
NY 100% MCS HP New York, LLC
TX 100% Evercare of Texas, L.L.C. (HMO)
DE 100% Lifemark Healthplans of Delaware, Inc.
NY 100% EverCare of New York, IPA, Inc.
DE 100%(5) Optigo, LLC
DE 100% The Ovations Press, Inc.
DE 50%(10) The Ovations Press/ Wurtman, L.L.C.

(1) **UnitedHealth Group Incorporated** ("UHG") (d/b/a UnitedHealth Group) is a Minnesota corporation whose shares of common stock are listed on the NYSE (i.e., it is publicly held). Name was changed from United HealthCare Corporation on March 6, 2000. It only does business in MN. It is the ultimate parent company of all the other UnitedHealth Group entities. It is not licensed as anything, i.e., it is not an HMO, insurance company, TPA, PPO, etc. It is a holding company. It should not be the party to any contract except for certain limited situations. This is not the entity that (i) manages or directly owns the HMOs (that is, for the most part, United HealthCare Services, Inc. "UHS" for management and UHS or UnitedHealthcare, Inc. for ownership), or (ii) offers the PPO or other products (that is United HealthCare Insurance Company).
(2) d/b/a: UHC of Ohio; also licensed in Kentucky.
(3) 50% is held by American International Group, Inc.
(4) Limited or single service health Plan
(5) This entity will dissolve or merge with another UHG legal entity.
(6) Ingenix, Inc. owns .01%. Established a representative office in Beijing, China.
(7) Also doing business as United HealthCare of Indiana, Inc. (IN); also licensed in Indiana.
(8) Licensed in Iowa and Nebraska.
(9) Licensed in Rhode Island and Massachusetts.
(10) 50% owned by Richard Saul Wurman.
(11) Licensed in Missouri, Illinois and Kansas.
(12) 10% is held by UHC International Holdings, Inc.
(13) **United HealthCare Services, Inc.** ("UHS") (formerly UHC Management Company, Inc. and before that Charter Med, Inc.) is a Minnesota corporation and wholly owned subsidiary of UnitedHealth Group. It is the technical employing entity (i.e., it files the payroll taxes in the 50 states) for substantially all UnitedHealth Group employees. It is qualified to do business in all 50 states, the District of Columbia and Puerto Rico. It is not licensed as an HMO or an insurance company but is licensed in several states as a PPO, TPA or UR agent. It is the management company for almost all the health plans and the insurance companies. It owns most of the assets (i.e., desks, computers etc.) used by all employees. It rents most of the space used by all UnitedHealth Group entities and people. Many of the specialty businesses, i.e., Evercare, URN, Optum, Healthmarc, are divisions of UHS, though URN and Optum are becoming their own companies. This is the entity that should be the party to the facilities, supply or other contracts that are for UnitedHealth Group generally. See p. 4 for UHS' assumed names.
(14) Licensed as a PPO or MCO in one or more states.
(15) Licensed as a UR Agent in one or more states.
(16) Licensed as a TPA in one or more states.
(17) Subsidiary being formed in Croatia.
(18) Licensed as a health care services contractor, but in process of withdrawing.
(19) Intentionally left blank.
(20) Other 50% is owned by UnitedHealthcare Asia Limited currently, but UnitedHealthcare International Asia, LLC will own 99% and UnitedHealthcare Asia Limited will own 1% after additional shares are issued.
(21) Also licensed in Virginia and the District of Columbia. United HealthCare of Virginia, Inc. merged into it effective 12/31/01 on approval of VA BOI, MIA, & MD DAT (later filing by VA Corp).
(22) 19.9% owned by ACN 3, LLC (name change pending).
(23) d/b/a: DICA, Inc. in Texas

(24) General partnership interest held by UHS and Commonwealth Physician Services Corporation. UHS also holds 99.4% of the limited partnership interests. Doing business as United HealthCare of Kentucky, L.P. in Indiana. Licensed as an HMO in Kentucky and Indiana.
(25) A Hong Kong "private" limited liability company owned 99% by UnitedHealthcare International Asia, LLC and 1% by UnitedHealthcare International, Inc.
(26) d/b/a: UnitedHealthcare, Inc., a Corporation of Delaware (obtained for use in Oklahoma).
(27) A Hong Kong limited liability company. Also qualified in Malaysia.
(28) Intentionally left blank
(29) UHG is the sole member of the UnitedHealth Foundation and the Foundation for Health Care Policy and Evaluation both MN non-profit organizations.
(30) **United HealthCare Insurance Company** is a Connecticut domestic health insurance company that is licensed as an insurance company in 49 states (not New York), District of Columbia , Puerto Rico, Guam and the Virgin Islands. This entity owns significant assets (such as desks, computers, etc.) and offers a variety of products including EPO, PPO, ASO/self-funded and indemnity.
(31) Licensed in Ohio only.
(32) Licensed in New York and the District of Columbia.
(33) Licensed in Illinois and Florida only.
(34) PhilamCare Health Systems, Inc. is 49.86% owned by PhilamLife and .28% owned by various individuals.
(35) 20% of Dental Benefit Providers, Inc. is owned by Irongate, L.L.C., a Delaware limited liability company.
(36) Not yet licensed.
(37) Branches in Republic of South Africa, the Netherlands, Sweden, and Germany. Withdrew from Hungary Jan. 2, 2001.
(38) Assumed names for UnitedHealth Networks, Inc. which must be used in the states listed below:
- UHN UnitedHealth Networks (obtained for use in New Hampshire)
- UHN UnitedHealth Networks, Inc. (obtained for use in Texas)
- United Networks (obtained for use in New York)
- UnitedHealth Network, Inc., a Corporation of Delaware (obtained for use in Ohio)
- UnitedHealth Networks, Inc., a Corporation of Delaware (obtained for use in Oregon)

(39) Ingenix International (UK) Limited owns 1%.
(40) Manages California Clinical Trials Medical Group.
(41) British Medical Journal owns 50%.
(42) One percent owned by Lifemark Corporation.
(43) One percent owned by ClinPharm International Ltd.

United HealthCare Services, Inc.'s filed assumed names/dbas include (continuation of footnote 13):

- Center for Health Care Policy and Evaluation (MN)
- Charter HealthCare, Inc. (NM, RI)
- Employee Performance Design (IL, KY, MN, NE, OR)
- EverCare (AZ, CA, CO, FL, GA, IL, IN, MD, MA, MI, MN, OH)
- GenCare PPO (IL, MO)
- Health Professionals Review (ME)
- HealthCare Evaluation Services (MN)
- Healthmarc (AZ, CA, GA, IN, IA, KY, ME, MD, MI, MN, MO, NV, NH, NJ, NC, RI, TN, TX, UT, VA)
- Healthmarc, Inc. (WV)
- HealthPro (AK, CT, IL, KY, MA, OH, VT)
- Institute for Human Resources (FL, OR, WA)
- Managed Care for the Aged (MN)
- Optum (MN, CA)
- Personal Decision Services (MN)
- UHC Management & Administrators (CA)
- UHC Management (VT)
- UHC Management Company (AK, MA, NH, UT, WV)
- UHC Management Company, Inc. (AL, AZ, AR, CA, CO, CT, DE, FL, GA, ID, IL, IN, IA, KY, LA, ME, MD, MA, MI, MN, MO, MT, NE, NJ, ND, OH, OR, PA, RI, SD, TN, TX, VA, WA)
- UHC of Illinois Inc. (IL)
- UHC of Missouri and United HealthCare of Missouri (MO)
- UMC Management Company, Inc. (OH)
- United HealthCare (MA, UT)
- United HealthCare Corporation (AZ, AR, CA, CO, CT, DE, FL, GA, ID, IN, IA, KY, LA, ME, MD, MO, MT, NC, ND, NE, NJ, OH, OR, RI, SD, TX, WA)
- United HealthCare Management (VT)
- United HealthCare Management Company, Inc. (IL, MI, OK, PA, TN, VA)
- United HealthCare Management Services (PA, NY)
- United HealthCare of Illinois, Inc. (IL)
- United HealthCare Services of Minnesota (NH)
- United HealthCare Services of Minnesota, Inc. (AR, FL, IL, OK, RI, SD, VT, WV)
- United Resource Networks (CA, GA, IL, IN, IA, MD, MI, MN, MO, NE, NY, NC, RI, UT)
- United Resource Networks, Inc. (CO, TN)
- UnitedHealth Group Incorporated (CA)

Transactions and Agreements with Affiliates

It was determined by the examiners that the terms and conditions of related party agreements are not reviewed for fairness and reasonableness by anyone at the Company. The review of these agreements is done by senior management at United HealthCare Services.

Lack of Agreement

The examiners first requested information on the make up of Net transfers to affiliates, page 6, column 1, line 13.2 of the 2001 Annual Statement on May 28, 2003. According to an email from the Company, its affiliate Ingenix, Inc. "has a division (formerly Subrogation Advantage) that assists in the recovery of third party liability health care expenses. When a recovery is made Ingenix will retain a portion of the recovery as part of their fee for negotiating payment from the third party and will then send the remaining amount to the health plan that had incurred the original cost of the claim. The Ingenix fee is a percentage of the recovery amount. The receivable, at December 31, 2001, represents reimbursements or refunds to the health plan for a recovery amount that had been received through the efforts of Ingenix Subrogation." Company employees at both Ingenix and United HealthCare of Alabama stated that neither United HealthCare Services, Inc. nor United Healthcare of Alabama, Inc. has an agreement with Ingenix, Inc.

Management Agreement

During the examination period ending December 31, 2001, the Company had no employees. It operated under an amended and restated *Management Agreement*, which was as of December 31, 1999, with United HealthCare Services, Inc. (UHS), Minnetonka, Minnesota. The agreement stipulated that the Company shall engage in the business of arranging for the provision of health care coverage to its enrollees, and UHS shall provide to the Company certain administrative, financial and managerial services necessary for its day-to-day operations. These included, but were not limited to the following:

- computerized management information systems;
- development and implementation of standardized contracts concerning the Company's subscribers and providers;
- preparation and filing of required applications and records;

- general administrative and financial services;
- placement and maintenance of insurance with respect to Company operations;
- underwriting services;
- internal audit services;
- marketing, sales, and provider relations;
- recruitment, compensation and supervision of all on-site personnel;
- retention of adequate office space, furniture and equipment;
- maintenance of appropriate books and records with respect to its activities, whereby all documentation is available for review by Company representatives and the Alabama Insurance Department; and
- the establishment of a payment process.

The Company was responsible for the costs associated with the following:

- payment of all debts and obligations of the Company;
- retention and compensation of independent auditors;
- payment of all fees and costs directly and indirectly related to the delivery of health care services and supplies to enrollees;
- establishment and maintenance of appropriate financial reserves, capital requirements and payments relating to deposits, annual fees and licensing fees;
- payments relating to premium, income, sales, or any other form of taxes;
- payments made to any independent broker, consultant or agent in regard to sales of the Company's products or programs or to other independent consultant or advisors;
- premiums for policies of insurance with the respect to the Company's operations;
- bad debt expenses; and
- activities and expenses related to the Board of Directors and Committees of the Company.

The monthly management fee for these services was calculated at a specific dollar amount multiplied by the number of persons covered by the Company's commercial managed care programs for that month, including individuals and their dependents whose employers or groups offer a self-funded health care coverage program, which utilizes the Company's provider network.

Another required monthly management fee was calculated by multiplying a specific dollar amount by the number of persons covered by the Company's Medicare managed care programs for that month.

Both of these monthly management fees were to be paid on or before the 10th calendar day of each month. The final calculation for the management fee for the calendar year shall be calculated within fifteen calendar days of receipt of the Company's audited financial statements. Any additional amounts required by such calculation or repayments by United HealthCare Services, Inc. to the Company of previously credited fees shall be made within thirty calendar days following receipt of the audited financial statements.

Termination of this agreement requires prior notification to the Alabama Insurance Commissioner.

Three prior examination reports, as of December 31, 1992, December 31, 1996, and December 31, 1999, recommended that the Company obtain approval of its management agreement from the Alabama Insurance Commissioner in accordance with ALA. CODE § 27-21A-4 (1975) and Section 13 of Alabama Department of Insurance Regulation Number 79.

The Company provided a letter, dated September 4, 2001, from the Alabama Department of Insurance, stating that the Company's "Amended and Restated Management Agreement by and between United HealthCare of Alabama, Inc. and United HealthCare Services, Inc." had been approved by the Commissioner.

Premium Allocation Agreement

United HealthCare Services, Inc. (UHS) on behalf of itself and as operator of those of its affiliated health maintenance organizations entered into a Premium Allocation Agreement, made effective as of January 1, 1998, with United HealthCare Insurance Company (UHI). The agreement included, but was not limited to, the following provision:

> "UHI shall be entitled to receive consideration received for insurance coverage marketed and issued in conjunction with products marketed and issued by the HMOs which shall be (i) fair and reasonable; (ii) determined according to actuarial review conducted at least annually; (iii) allocated in conformity with customary insurance accounting practices consistently applied."

The Premium Allocation Agreement was not approved by the Alabama Department of Insurance. This agreement violates of ALA. CODE § 27-21A-6(c) (1975), which requires that "Any officer, or director, or any member of any committee or any employee of a health maintenance organization who is charged with the duty of investing or handling the organization's funds shall not deposit or invest such funds except in the organization's name..." ALA. CODE § 27-41-2 (5) (1975) defines an investment as any asset owned by an insurer. ALA. CODE § 27-41-2 (6) (1975) defines an eligible investment as any investment permitted by ALA. CODE § 27-41-7 to 27-41-35, (1975) inclusive, provided the investment meets all the other requirements of this chapter. Finally, ALA. CODE § 27-27-29 (1975) requires that "Every domestic insurer shall have, and maintain, its assets in this state..."

Tax Sharing Agreement

On November 15, 1995, the Company entered into a Tax Sharing Agreement, made effective as of January 1, 1990, with its ultimate parent, UnitedHealth Group Incorporated, formerly United HealthCare Corporation (UHC) and other affiliated companies in the UHC group. The agreement applied to tax returns beginning with the year ended December 31, 1990, and for each subsequent taxable year. The agreement included, but was not limited to, the following provisions:

- Each member shall pay UHC an amount equal to the full separate federal, state and local (if any) income tax liability attributable to the net taxable income of such member that would have been paid if such member had filed separate federal, state and local income tax returns.

- Any federal surtax exemption available to the group shall be allocated proportionately to UHC and the members based upon the taxable income for such tax year produced. In the event any member has a loss, for the purpose of allocating the surtax exemption for such tax year, such member shall be deemed to have no federal taxable income.

This agreement was not approved by the Alabama Department of Insurance, as required by Alabama Department of Insurance Regulation Number 79 Section 13, paragraph 3, which states that: "Any management contractor who shall manage the financial affairs, investment affairs or any of the health care

activities of the HMO shall be subject to prior approval by the Commissioner with the advice of the State Health Officer..."

Subordinated Revolving Credit Agreement

The Company ("Borrower") entered into a subordinated revolving credit agreement with UnitedHealth Group Incorporated, formerly United HealthCare Corporation ("Lender"), effective December 1, 1999. The agreement included, but was not limited to, the following provisions:

- Lender agrees to lend and re-lend amounts requested by the Borrower, not to exceed the aggregate principal amount, if any, set forth in Borrower's Addendum to be outstanding at any one time.
- Lender may require that each loan hereunder be evidenced by a note.
- Interest on the outstanding balance of each loan shall be payable at the one month London InterBank Offered Rate in effect on the last business day of the calendar month prior to the calendar month for which interest is being calculated plus fifty basis points.

The agreement was used once in the fourth quarter of 2001. The Company borrowed five million dollars in October 2001 and paid it back in November 2001.

The Company provided copies of letters, dated November 9, 1999 and October 28, 1999, sent to Mr. John MacBain at the Alabama Department of Insurance requesting approval of this agreement. According to the Company, they have not received any correspondence from the Department concerning this agreement.

Mr. MacBain is one of the Alabama Department of Insurance's consulting actuaries and is not in a position to approve or disapprove intercompany agreements for the Department of Insurance. This agreement was not approved by the Alabama Department of Insurance, which is required by Alabama Department of Insurance Regulation Number 79 Section 13, paragraph 3, which states that: "Any management contractor who shall manage the financial affairs, investment affairs or any of the health care activities of the HMO shall be subject to prior approval by the Commissioner with the advice of the State Health Officer..."

Agreement for the Provision of Services

This agreement, effective January 1, 1996, was between United Behavioral Health, Inc. (UBH) and the Company. This agreement sets forth the terms and conditions under which UBH provided and/or arranged for the provision of certain mental health and substance abuse services to individuals covered by benefits plans sponsored or issued by the Company.

The agreement was an exclusive agreement regarding the rights, responsibilities, and other conditions for the provision and payment of Mental Health and/or Substance Abuse (MHSA) Services and/or Utilization Management (UM) Services. The responsibilities of UBH shall be limited as defined by the terms of this agreement.

- UBH is responsible for arranging for a Provider network to provide mental services to covered persons.
- UBH shall assure that 90% of all covered persons who reside within the service area are within 30 miles or 30 minutes of a Provider.
- UBH shall provide to all covered persons a 24-hour toll-free telephone line, for referral for required services, crisis intervention, and responding to inquiries regarding available services.

This agreement may be terminated:
-by either party, with sixty days written notice in the event of a material breach by the other party of any term of the agreement.
-by either party, at any time for a "without cause" termination upon 120 days written notice.

Fees related to this agreement were approximately $4,405,000 in 2001, and were included in medical services expenses.

Transplant Services Agreement

The Company had a transplant services agreement with United HealthCare Service, Inc. (UHS), Minnetonka, Minnesota, on behalf of its division, United Resource Networks (URN), signed November 19, 1999. According to this agreement, UHS shall provide certain services to the Company, including the following:

- arrangements for access to participating providers for the provision of certain transplant services as described in the Network Access Appendix;
- payment for services in accordance with terms as stipulated in the Appendix;
- statement of conduct in reference to discriminating or differentiating in the rendering of transplant services to members;
- assistance in obtaining cooperation from participating providers concerning utilization management and quality assessment programs;
- maintenance of all federal, state, and local licenses, certifications and permits necessary for the provision of transplant services for all Healthcare professionals employed by or under contract to the provider;
- verification that each party may audit and/or copy pertinent files and records directly related to the agreement;
- each party deemed responsible for claims, liabilities, damages, or judgments that may arise as a result of negligence or intentional wrongdoing; and
- payment of monthly fee for each member enrolled or covered by plans sponsored or issued, as of the first day of each month. The fee for this service was increased effective January 1, 2001 and again in 2003.

This agreement may be terminated by either party, upon thirty days prior written notice to the other party, in the event of a material breach of the agreement, or in the event that the other party is no longer an affiliate of United HealthCare Group. Either party may also terminate upon ninety days prior written notice to the other party, which may be given at any time after the agreement has been in effect for three years.

The Company provided letters, dated July 10, 2001 and September 4, 2001 from the Alabama Department of Insurance, stating that the Company's "Amendment to the United HealthCare Services, Inc. Transplant Services Agreement" had been approved by the Commissioner.

Fees related to this agreement were approximately $76,000 in 2001, and were included in medical services expenses.

OPTUM Services Agreement

The Company had an agreement, effective November 1, 1999, with OPTUM, a division of United HealthCare Services, Inc. (UHS), to provide a 24-hour call-

in service, called *Care24*, to its enrollees. Services included in various addenda were as follows:

Care24; and
Health and Well Being Information

Administrative services included the following:

- standard aggregate reports within 45 days after the end of the reporting period;
- communications materials and activities;
- responsibility for damages and insurance;
- regulatory compliance and filing;
- maintenance of books and records.

Other services were available upon mutual agreement of the parties.

The agreement can be terminated after the initial term (ending December 31, 2000), with ninety days written notice, and will automatically renew for additional one-year terms.

Fees related to this agreement were approximately $1,163,000 in 2001, and were included in medical services expenses.

The first Restated Participating Plan Addendum of this agreement was approved by the Alabama Department of Insurance per a letter from the Alabama Department of Insurance dated September 4, 2001.

Diversified Pharmaceutical Services Agreement

The Company had an agreement with United HealthCare Services, Inc. (UHS), to provide administrative services related to pharmacy management and claims processing for its enrollees. UHS contracts with Diversified Pharmaceutical Service, Inc. (DPS) for the provision of these services. It operated under the service agreement, which was amended and restated as of January 1, 1998. DPS provided certain services, which included:

- prescription drug benefit management services to health maintenance organizations, health insurance companies and other health plans and health plan administrators owned or controlled by UHS;
- sufficient personnel and resources to successfully administer UHS and companies' pharmacy programs and provide the services contemplated by this agreement;
- monthly reports to UHS regarding the personnel;
- claims processing services related to claims for prescriptions dispensed on or after the "Claims Processing Commencement Date" for each company;
- timely notice on a periodic basis to UHS, via standard reports or otherwise, of the amount of companies' liability for claims processed;
- establishment of a pharmacy network strategy consistent with the overall strategy for UHS' health plan and health insurance business;
- provision of clinically-based utilization and cost management programs and services relating to Prescription Drug services, including DUE (Drug Utilization Evaluation) and DUR (Drug Utilization Report) programs, formulary transition programs, generic drug utilization programs and other related education initiatives and communications to participants or participating providers;
- the use of the drug formularies approved by DPS's National Pharmacy and Therapeutics Committee, or one or more drug formularies adopted by UHS based on a DPS template formulary;
- participation in the rebate program with respect to all benefit plans underwritten, issued or administered by such companies;
- responsibility for responding to inquiries from participation pharmacies regarding the services provided by DPS; and
- prescription alert services made available via on-line communication (known as the Diversified AlertCare service) to participating pharmacies.

Fees related to this agreement were approximately $714,000 in 1999, and were included in operating expenses. Pharmacy rebates on certain pharmaceutical products were based on member utilization. Rebates amounted to approximately $2,538,000 in 1999, and were included as a reduction to medical services expenses.

It was noted that the agreement with DPS was terminated on May 31, 2000.

Vision Care Services Agreement

United HealthCare Service, Inc. (UHS), Minnetonka, Minnesota, on behalf of health plans that are owned and/or managed by UHS and its affiliates had a vision care services agreement with Coordinated Vision Care, Inc. ("CVC"), a vision benefit management company. According to this agreement, CVC shall provide certain services to UHS, including the following:

- manage and arrange for participating providers to provide vision care services to members;
- establish and maintain a credentialing process to which all participating providers shall be subject;
- provide participating providers with an inventory of frames to display in their offices;
- establish and maintain contractual relationships with wholesale laboratories for the fabrication of prescription ophthalmic lenses.
- make initial determinations on whether services and/or supplies requested by or on behalf of a member or for which a member has requested reimbursement are vision care services;
- process claims for vision care services;
- attempt to resolve any disputes that arise regarding coverage;
- provide consulting services which relate to vision benefit designs, underwriting considerations and marketing strategies;
- provide UHS with monthly or quarterly reporting, accrediting agency reporting, and specialized reporting regarding the vision care services managed and arranged by CVC; and
- establish and maintain a quality management program, provider credentialing and re-credentialing program, and other programs.

UHS is responsible for the costs associated with the following:

- provide CVC with a current list of participating plans' members at least thirty days before the effective date, and at least weekly thereafter;
- any claims for vision care services related to retroactive adjustments of eligibility greater than sixty days; and
- regulatory compliance associated with the vision benefits set forth in the benefit contract(s) and for filing the agreement with federal, state and local governmental authorities as required by any applicable law or regulation.

An addendum to this agreement was entered into between United HealthCare of Alabama, Inc. ("Company") and Coordinated Vision Care, Inc. ("CVC") effective October 1, 2001. In addition to the responsibilities outlined in the agreement, CVC and the Company agree to assume the following responsibilities:

- CVC agrees that it shall maintain at its principal office books and records that are usual and customary for the services provided under this agreement for the duration of the agreement and at least five years thereafter.
- The Company acknowledges that it retains the ultimate responsibility to assure delivery of all vision care services required by the benefit contract.
- CVC shall provide a copy of its provider manual to all providers at the time they are reviewing/evaluating CVC's Provider Participation Agreement for participation in CVC's provider network.
- CVC will provide information regarding payment and incentive arrangements to all providers at the time they are reviewing/evaluating CVC's Provider Participation Agreement for participation in CVC's provider network.
- The Company shall provide CVC with a copy of its provider manual, and will provide CVC with written notice of any changes to the provider manual.
- The Company will pay CVC a per member per month fee for each member as set forth in the applicable rate appendix, as compensation for CVC's network and management services.

The addendum between United HealthCare of Alabama, Inc. ("The Company") and Coordinated Vision Care, Inc. ("CVC") effective October 1, 2001 was approved by the Alabama Department of Insurance per a letter from the Department of Insurance dated September 4, 2001.

Fees related to this agreement were approximately $21,000 in 2001, and were included in medical services expenses.

Dividends to Stockholder

The Company paid dividends of $5,748,508 in 2001 to its sole shareholder.

FIDELITY BOND AND OTHER INSURANCE

The Company was a named insured on a financial institution bond issued by National Union Fire Insurance Company of Pittsburgh, Pennsylvania, which met the minimum requirement of the NAIC Financial Examiners Handbook. This bond covered the following: employee dishonesty, loss inside the premises, loss outside the premises, money orders and counterfeit paper currency, and depositors forgery coverage.

In addition to the aforementioned fidelity bond, the Company also maintained the following coverage to protect the Company against hazards to which it may be exposed:

- Auto Coverage
- Directors, Officers and Corporate Liability Insurance
- Commercial General Liability
- Commercial Catastrophe Liability
- Managed Care Professional Liability
- Blanket Crime Policy
- Real Property including Building and Personal Property
- Workers Compensation and Employee Liability

The coverage and limits carried by the Company were reviewed during the course of the examination and appeared to adequately protect the Company's interests at the examination date. The records of these insurance policies were being kept in Minnetonka, Minnesota. The Company was not in compliance with ALA. CODE § 27-21A-16 (f) (1975), which requires that "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15, which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

EMPLOYEE AND AGENTS WELFARE

It was determined that the Company has no retirement plan, deferred compensation and/or other benefit plans, since all personnel are employees of United Healthcare Services, Inc., which provides services to the Company under the terms of a management agreement.

SPECIAL DEPOSITS

The State of Alabama held, as a statutory deposit, a $100,000 par value, 7.5% interest rate, U.S. Treasury Note, with a maturity date of May, 15, 2002. At December 31, 2001, this bond had a statement value of $100,368 and a fair value of $102,156.

FINANCIAL CONDITION/GROWTH OF THE COMPANY

The following table shows assets, liabilities, capital and surplus, and net premium income for 1999-2001, as disclosed in the Company's filed Annual Statements.

	1999	2000	2001
Net Admitted Assets	$ 93,561,946	$115,715,641	$133,380,386
Total Liabilities	$ 80,093,919	$ 85,519,636	$ 74,444,955
Total Capital and Surplus	$ 13,468,027	$ 30,196,005	$ 58,935,431
Net Premium Income	$386,697,170	$405,033,189	$394,789,266

MARKET CONDUCT ACTIVITIES

For most aspects of consumer relations, the Company is regulated by the Alabama Department of Public Health (ADPH). During the examination period, ADPH conducted several audits throughout the period under examination. The ADPH conducted a comprehensive audit, dated August 14-18, 2000.

The Alabama Department of Public Health conducted a claims audit on United HealthCare of Alabama, Inc. on July 29-August 2, 2002. The audit resulted in finding that United HealthCare of Alabama, Inc. was out of compliance with both the Alabama Prompt Pay Law and Public Health Rule 420-5-6.06(13)(a).

On May 29, 2003, the Alabama Department of Public Health deemed the Company's plan of correction for the 2002 annual claims audit acceptable.

On July 14-18, 2003, ADPH conducted an audit on the Company's operations: Organization and Quality Assurance/Utilization Review.

Territory

As of December 31, 2001, the Company was licensed to transact business in the state of Alabama only. The certificate of authority was inspected and found to be in order.

The Alabama Department of Insurance and the Alabama Department of Public Health authorized the Company to market business in the following Alabama Service areas or counties at the examination date.

Autauga	Colbert	Hale	Mobile
Baldwin	Conecuh	Houston	Monroe
Barbour	Coosa	Jackson	Perry
Bibb	Covington	Lauderdale	Pickens
Blount	Crenshaw	Jefferson	Pike
Bullock	Cullman	Lawrence	Shelby
Butler	Dale	Lee	St. Clair
Calhoun	Dallas	Limestone	Talladega
Cherokee	Dekalb	Lowndes	Tallapoosa
Chilton	Elmore	Macon	Tuscaloosa
Choctaw	Escambia	Madison	Washington
Clarke	Etowah	Marshall	Wilcox
Cleburne	Franklin	Montgomery	Walker
Coffee	Greene	Morgan	

The Company failed to report the addition of Butler, Cherokee, Dekalb and Pike counties as new territories for operation in its 2001 Annual Statement.

Plan of Operation

The Company, a for-profit health maintenance organization (HMO), offered its enrollees a variety of managed care programs and products through contractual arrangements with health care providers. These included fully insured and self-funded point-of-service (POS) and HMO products. The HMO products

included a closed access network that emphasized the role of the primary care physician and an open access plan. The POS, or "plus" products featured closed access and open access models with out-of-network benefits. The Company also offered a Medicare risk HMO product called "Medicare Complete" to its senior members.

Lines of business, as reported in the 2001 Annual Statement included:

- Comprehensive (hospital and medical)
- Medicare Supplement
- Title XVIII - Medicare

In order to provide the most comprehensive health care to its members, the Company relied on a variety of delivery systems. Those delivery systems were designed to meet the customers' needs for preventive care and comprehensive health care. The total delivery system included:

- Hospitals
- Skilled nursing facilities
- Rehabilitation facilities
- Home health care
- Mental Health/Substance Abuse
- Pharmacy services
- Other ancillary services
- Primary care physicians
- Specialty physicians

Provider Contracts

Provider contracts and turnover rate matters are mostly reviewed by the Alabama Department of Public Health. The examiners' review of the number of provider additions and deletions in the years 2001 and 2002 revealed that the Company had a large number of provider terminations in the first quarter of 2001. Most of the provider terminations were due to the Company refusing to renew contracts of providers that refused to sign all payor agreements or those providers that did not see a lot of enrollees. In addition, Company management indicated that 1.) there was a higher than usual amounts of provider retirements and relocations and 2.) the Company lost a large number

of anesthesiologists in the Mobile area. The Company is allowed to use these practices, which were known by the ADPH and no further explanation was required from the Company.

Policy Forms and Underwriting Practices

The United HealthCare of Alabama, Inc. Underwriting Department was responsible for the development and implementation of underwriting and pricing policies. The underwriting manual outlined the different products available and the sales process for the different group sizes and products.

The Company bases underwriting for a plan on various factors including the following:

- Any significant changes in enrollment in the plan
- The turnover rate of enrolled subscribers
- The age of each employee, or alternatively, aggregate age information categories of not more than five-year increments
- The gender of each employee. This may be compiled as aggregate information by category.
- The number of dependents, if available.
- Whether the employee is eligible for "single" or "family" coverage, and if three-tier, the number of "dual coverage."
- Whether the employee elects "single" or "family" coverage, and if three-tier, the number of "dual coverage."

New plan designs, benefits, etc., during the examination period were added to rate cards, and changes were filed with the Life and Health Division of the Alabama Department of Insurance.

The examiners selected a sample of 132 reinstated policies during the examination period. The Company initially did not provide eleven or 9% of the requested files. These records should be kept and organized for examination purposes as required by Alabama Department of Insurance Regulation Number 79 Section 15, which requires that:

"... Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions and affairs..."

The Company subsequently provided the missing reinstated policy files. However, these files were not provided within the ten days required by Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner. When the requested record or response is not produced or cannot be produced by the insurer within ten working days, the nonproduction shall be deemed a violation of this rule, unless the Commissioner or duly appointed person making the request grants an extension in writing or the insurer can demonstrate to the satisfaction of the Commissioner that there is a reasonable justification for the delay."

Advertising and Marketing

The sale and advertising material provided by the Company was maintained in accordance with Section 6 of Alabama Department of Insurance Regulation Number 79.

The Company filed the certificate of compliance with the annual statement in accordance with the aforementioned Regulation.

The examiners noted two problems during the review of the Company's files.

1.) The Company's renewal notices sent to its customers during 2001 and 2002 are ambiguous and misleading. The letterhead is listed as "UnitedHealthcare" on the first line, followed by "A UnitedHealth Group Company" on the second line with "United Healthcare of Alabama, Inc." on the third line. The examiners could not locate any companies with the names of "UnitedHealthcare" or "A UnitedHealthGroup Company" on the company's organizational chart. In addition, the renewal notice states, "You asked for it, you got it! UnitedHealthcare is proud to offer you and your employees Life/AD&D coverage." This is misleading because to the examiners' knowledge there is no such company as "UnitedHealthcare." In

addition, United Healthcare of Alabama, Inc. is not licensed to sell life or AD&D coverage. The Employer Application does list prominently that the application is to be provided to United HealthCare and in a sub-heading below it states "Insurance Products provided by United Health and Life Insurance Company." The examiners did not find "United Health and Life Insurance Company" listed on the Company's organizational chart.

2.) The Company's "Urgent Reinstatement Fax" documents list on the first line "UnitedHealthcare" and on the second line "A UnitedHealth Group Company." Nowhere on the fax is United HealthCare of Alabama listed. In addition, the fax instructs the customer to "Mail Certified Funds, Automatic Withdrawal Form, and Voided Bank Check" to United Healthcare in Lake Mary, Florida. In addition to the company names being ambiguous and misleading, the Company was directing the customer to send its premiums to an entity located outside the state of Alabama. ALA. CODE § 27-21A-6 (c) (1975) requires that "Any officer, or director, or any member of any committee or any employee of a health maintenance organization who is charged with the duty of investing or handling the organization's funds shall not deposit or invest such funds except in the organization's corporate name..." ALA. CODE § 27-27-29 (1975) requires that "Every domestic insurer shall have, and maintain, its assets in this state..."

ALA. CODE § 27-21A-13 (3) (d) (1975) requires that: "No health maintenance organization unless licensed as an insurer may refer to itself as a licensed insurer or use a name deceptively similar to the name or description of any insurance or surety corporation doing business in this state."

Alabama Department of Insurance Regulation Number 79 Section 12 requires that "No name other than that approved by the Commissioner may be used. The name of the HMO may not be changed without prior approval of the Commissioner. Any name which is misleading as to the purpose or type of organization or which is deceptively similar to the name of another licensed HMO shall not be used by the HMO."

Alabama Department of Insurance Regulation Number 79 Section 6 states that "Advertising includes printed and published material, descriptive literature and sales aids, sales talks and sales materials, booklets, forms and pamphlets, illustrations, depictions and form letters, newspaper, radio, television or direct mail advertising..."

Alabama Department of Insurance Regulation Number 79 Section 6 requires that "...Advertising must be truthful and not misleading in fact or implication. Words or phrases shall not be used whose meaning is unclear, ambiguous..." "...Words, phrases or illustrations shall not be used in a manner which misleads or has the capacity or tendency to deceive or mislead." "...All advertisements must contain the name and address of the HMO as filed with the Commissioner."

ALA. CODE § 8-19-5, (1975) states that "The following deceptive acts or practices in the conduct of any trade or commerce are hereby declared to be unlawful:...(2) Causing confusion or misunderstanding as to the source, sponsorship, approval, or certification of goods or services..." "(27) Engaging in any other unconscionable, false, misleading, or deceptive act or practice in the conduct of trade or commerce."

Claims Payment Practices

The examiners reviewed a sample of 132 claims files on paid and denied claims. These were used for the study of the turnaround times on claims and were selected using the listings of claims paid in 2000 and 2001 through both UNET and COSMOS claim payment systems. The examiners were able to verify dates of receipt and payment or response on all of the claims. Timeliness of response by either payment of the claim or notification of nonpayment to the claimant was studied. Adequacy of documentation was also reviewed. It was determined that the Company responded within the 30 days required for electronic claims and the 45 days required for clean paper claims. However, see "Alabama Department of Public Health Claim Review" – page 36 for related discussion.

Location of Claim Files

The Company's claim files were kept in Minnesota. These records should be kept in a location approved by the Commissioner as required by ALA. CODE § 27-21A-16 (f) (1975)

Alabama Department of Public Health Claim Review

On October 4, 2002, the Commissioner received a copy of the report on the Company's claims handling practices issued by the Alabama Department of Public Health (ADPH). The report pointed to following matters:

- The Company did not provide an aged claim status report of all unpaid ER claims. The Company states that there is an inability to track and report the aging status of emergency claims as a separate category of claims.
- The Company states an inability to track and report the aging status of paper claims by provider and pend reason separate from an overall inventory report of aging electronic and paper claims.
- All reports, interviews, policies and audits of sampled claims indicated that the Company is not tracking resubmitted claims for the 21 day resubmission processing requirement in the Alabama Prompt Pay law. Upon receipt of a resubmitted claim, the claim is assigned a new number and processed as a new claim. While processors have access to previous claim information, the Company is not tracking for the 21 day resubmission deadline.
- All reports, interviews, and policies indicated that providers are not receiving written notification if a claim is pended "internally" and not denied or paid within the required 45, 30 or 21 days.
- The Company assigns a new claim number to a claim regardless of how many times a claim may be resubmitted. This means that a paper claim may have been submitted a number of times before being determined to be "clean." Therefore, aging reports are suspect. In addition to assigning new claim numbers to resubmitted claims, the Company does not track re-submissions per the Alabama Prompt Pay Law.
- The Company does not have a policy that sets a maximum time limit for the pending of a claim before it is either denied or paid.

On May 29, 2003, the Company provided ADPH an acceptable plan of correction, which is currently being implemented and is monitored by the Alabama Department of Public Health.

Claim Checks Issuance

When reviewing a sample of paid claims, the examiners determined that the checks the Company issued for payments of claims were cashed (or deposited) within the following number of days.

Number of Checks Cashed	Days until presentation to Bank
1	2
4	3
11	4
17	5
19	6
16	6
8	8
6	9
7	10
1	12
1	13
1	15
1	23

The average number of days for a claim check to be cashed (or deposited) was 6.67 days. In reviewing one of the litigation files, the examiners found an internal letter instructing one of the Company employees to hold a claim check for 48 hours before mailing. The letter was dated June 18, 2002 and was from a compliance assistant to another employee at the Company: "Attached is payment verification on the claim of Dr. Routman in the above matter. The check should be written and mailed sometime tomorrow (48 hours after "paid" date)."

Mental Health Benefits

The examiners determined from reviewing the Company's schedule of benefits that the Company imposed a limit on the number of outpatient mental health and substance abuse services visits. The Company's benefits offered were limited to 52 mental health visits per calendar year and did not have the same limit on medical and surgical services. This was not in compliance with ALA. CODE § 27-54-4 (b) (1) (1975), which stipulates that:

"The group health benefit plan shall offer to provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses."

Pharmacy Claims

The examiners selected a sample of 132 claims from the paid claims detail supplied by the Company. The examiners then requested the claim files to verify the dates the claims were received and paid and to perform various other tests on the canceled claims checks.

The Company was unable to provide the examiners with 39 of the paid claims files that were sampled. These 39 claims were pharmacy claims. The Company explained that the checks are written by Medco, the company that processes the pharmacy claims for the Company, and because of this the Company does-not have access to the canceled checks. The Company should have a database or the ability to query a database by policyholder and/or claim amount that ties back into specific "batch" payments, which ultimately tie back into a canceled check or wire transfer.

The Company's explanation for this is that United Healthcare Services "UHS" contracts with Medco to pay all of the pharmacy claims for the health care plans under UHS. Medco is then responsible for paying the pharmacy claims for UHS and many other different health care providers in large pools of claims to the individual pharmacies. The Company reimburses UHS for the pharmacy claims through the Intercompany Settlement System. Company management responded that: "Given the amount of time it will take to pull the requested documentation to indicate how the pharmacy claim payments tie to the UnitedHealthcare general ledger, we will not be providing the sample items requested by Anne Ogle and Shaun Sori."

This failure to provide information necessary for the exam is a violation of Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

Treatment of Members and Claimants

During the review of the Company's complaint handling procedures, the examiners did not find any guidelines requiring Company personnel to respond to complaints received through the Alabama Department of Insurance within ten days. Alabama Department of Insurance Regulation Number 118, Section 6, requires that:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

and Alabama Department of Insurance Bulletin dated January 31, 1963, states:

"The Department of Insurance henceforth will take the position that an insurance company must answer both the policy holder and this Department within ten days after receipt of a departmental complaint."

Policyholder Complaints

The Company maintained consumer complaint files that were received either directly from the customer or through the State's Department of Public Health or Department of Insurance Consumer Division. These files were maintained by year and insured name.

The Company's pre-established complaint handling procedures provided for prompt and proper handling of the complaints. Guidelines were included for the handling of every type of complaint. The operation manager was responsible for monitoring trends in complaints.

During the examination period, the Company received the following complaints/inquiries:

YEAR	NUMBER OF COMPLAINTS/INQUIRIES
2000	628
2001	760

A review of a sample of complaints revealed that the Company resolved the complaints received in a timely and satisfactory manner. Out of the sample of 132 complaint files requested, the Company did not provide three complaint files.

The sample of complaints selected revealed that the Company overturned denials upon receipt of complaints on approximately 50% of the reviewed files. This trend was attributed by the Company to the fact that it had two different networks, PPO and HMO, where a provider could be participating in one and non-participating in the other. This, in addition to the Company's efforts to consolidate the two networks during 2000, created situations where HMO enrollees mistakenly visited a PPO provider.

A review of the complaints received subsequently, in 2002, revealed that the number of overturned claim denials based on out-of-network provider visitation declined compared to the number of complaints received during the examination period.

Compliance with Agents' Licensing Requirements

The examiners reviewed Company practices on agent licensing to determine whether the agents, who sold the Company policies, were properly licensed.

The examiners requested the licenses of a sample of 191 commission paid producers to make sure that the Company only pays commissions to properly licensed and appointed agents and agencies. The Company did not provide three of the requested commission paid producer files. The Company does not properly maintain its producer files to contain all necessary documentation supporting appointment of such producers.

For the producer licenses the Company did not provide, the examiners requested detail on the commissions they were paid. This was done to determine the appropriate contingent liability for the potential fine to be levied

by the Commissioner in accordance with ALA. CODE § 27-7-35.1 (1975), which states:

"(a) An insurance company or insurance producer shall not pay a commission, service fee, brokerage, or other valuable consideration to a person for selling, soliciting, or negotiating insurance in this state if that person is required to be licensed under this chapter and is not so licensed.
(b) A person shall not accept a commission, service fee, brokerage, or other valuable consideration for selling, soliciting, or negotiating insurance in this state if that person is required to be licensed under this chapter and is not so licensed.
(c) Renewal or other deferred commissions may be paid to a person for selling, soliciting, or negotiating insurance in this state if the person was required to be licensed under this chapter at the time of the sale, solicitation, or negotiation and was so licensed at that time.
(d) An insurer or insurance producer may pay or assign commissions, service fees, brokerages, or other valuable consideration to an insurance agency or to persons who do not sell, solicit, or negotiate insurance in this state, unless the payment would violate chapter 12 of this title.
(e) Any insurer or producer violating this section shall be liable for a fine in an amount of up to three times the amount of the commission paid. The fine shall be levied and collected by the commissioner. Upon failure to pay the fine the commissioner may, in his or her discretion, revoke the license of the producer or the insurer's certificate of authority, or both."

Commissions were paid to the following producers and the Company did not provide evidence that the following producers were licensed in the state of Alabama.

Managed Benefits Inc.	$2414.43
SGP Benefits of Texas Inc. Houston	$ .04
Professional Insurance Services	$ 37.45
Total	$2451.92

According to the above-mentioned ALA. CODE § 27-8-27 (b) (1975), the Company is potentially liable for a fine totaling three times the total amount of commissions paid to the unlicensed producers. This amounts to $7,355.76. In addition to this, the examiners' reconciliation of the commission paid producer listing to the Annual Statement revealed that the total commissions paid reported on the 2001 Annual Statement was $37,663.38 more than what was

reported as total commissions paid in the listing. Subsequent to the on-site examination work, the Company provided another paid commissions file which the examiners did not examine or test. The Vice President of Finance, United Healthcare – Gulf States, represented to the examiners that "...To the best of my knowledge and belief, this file includes commissions paid to agents who were properly licensed in the State of Alabama, except for any findings that you might have noted already during the course of your examination. The file that I am referencing provides further detail and reduces the unreconciled difference to $1,242.19, an amount that we believe to be immaterial..."

After further attempts by the examiners to receive more information on the reasons the above-mentioned producers were paid commissions, the Company explained that Managed Benefits Inc. was paid commissions on sales of policies issued by the Company in Virginia. The Company also explained that this was a mistake and that the Company will correct this when the group renews. A Company representative subsequently explained that the policy was not sold in error and that the Company sold the policy to a group in Alabama that is affiliated with the group in Virginia.

The Company also explained that Professional Insurance Service was actually Professional Insurance Association, which was determined to be a licensed producer by the examiners. However, the Company did not provide evidence that these two entities were the same.

The examiners also requested files of producers that sold certain policies, which were in effect during the exam period. At first, the Company did not provide the files of 22 of the requested 132 sample of selling producers. The Company does not keep all producer records at its headquarters in Birmingham Alabama, moreover; it does not properly and adequately keep its producer files to include all the necessary documentation, such as the correspondence with agents. The Company was not in compliance with ALA. CODE § 27-21A-16 (1975), which requires that:

"All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15, which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

It was subsequently determined that the selected producers were licensed. The Company provided license and appointment forms on 18 of the missing producer files. The other four were confirmed as licensed by the Alabama Department of Insurance.

Location of Records

The Company maintained producer records in Hartford, Connecticut. This was not in compliance with ALA. CODE § 27-21A-16 (1975), which requires that:

"All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner" and Alabama Department of Insurance Regulation Number 79 Section 15, which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

Terminated Agents

During the review of the terminated agent files, the examiners requested the files of all 127 terminated agents during the examination period. The Company did not provide ten of the requested files. Out of the files provided, 45 did not have any documentation supporting the termination of the producer. The Company does not properly manage its terminated agent files; moreover, these files were kept in a location outside of the State of Alabama without obtaining the Commissioner's approval. These records should be kept in a location approved by the Commissioner and available to provide for examination purposes as required by ALA. CODE § 27-21A-6 (f) (1975), which states that:

"All records necessary for the complete examination of the health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner."

The examiners were not able to verify compliance with termination notification period on 55 of the 127 requested files. It was determined that the termination notification period on the other 72 terminations was reasonable and in compliance with ALA. CODE § 27-8-24 (c) (1975), which requires that:

"Upon termination of the appointment of an agent, or as soon thereafter as possible, and immediately upon completion of the insurer's investigation, the insurer shall file with the Commissioner a written statement of the facts relative to the termination and the date and cause thereof..."

Rate Filings

The Company's rates were filed with and approved by the Alabama Department of Insurance in accordance with Section 5 of the Alabama Department of Insurance Regulation Number 79. The examiners verified with the consulting actuary that all of the Company's rate and group size factors were filed and approved by the Alabama Department of Insurance.

ALA. ADMIN. CODE 482-1-116 Section (.05) (g) (2) (2002) requires that:

"Each small employer carrier shall file with the Commissioner annually on or before March 15, both of the following:
a. An actuarial certification certifying that the carrier is in compliance with this regulation... A copy of the certification shall be retained by the small employer carrier at its principal place of business."

The Company did file the actuarial certification, but did not keep this certification at its headquarters in Birmingham, Alabama.

REINSURANCE

It was noted that the Company did not submit its general liability and reinsurance policies to the Commissioner with each annual report. Therefore, the Company is in violation of Alabama Department of Insurance Regulation Number 79 Section 14, which requires: "Evidence of the existence of insurance or a plan for self-insurance approved by the Commissioner must be submitted at least 30 days prior to the expiration date of the policy and with each annual report."

The examiners determined that there were no maximum benefit limitations the Company would pay on a member in his or her lifetime. The reinsurance contract specified a maximum amount of $2 million per member per year.

Assumed Reinsurance

The Company did not assume any reinsurance during the examination period.

Ceded Reinsurance

During the course of this examination, the Company had two reinsurance agreements.

1.) Beginning January 1, 2000, the Company ceded reinsurance under an HMO excess risk reinsurance agreement to Continental Assurance Company.

Terms of Coverage	12 Months at January 1, 2000
Company's retention	$150,000 deductible
Reinsurer's limits	$1,000,000 per member per year

2.) Beginning January 1, 2001, the Company ceded reinsurance under a non-proportional stop loss coverage contract to United HealthCare Insurance Company.

Terms of Coverage	January 1, 2001 and continue in full force until terminated
Company's retention	$150,000 deductible + 10% coinsurance
Reinsurer's limits	$2,000,000 per member per year

3.) In addition, the Company entered into a transplant service agreement with United HealthCare Services, Inc. (UHS). The agreement was effective May 22, 1998 and will remain in effect until it is terminated.

The Company is solely responsible for the payment of all transplant services rendered to members, except for member co-payments, deductibles, or charges for services not covered under the member's benefit contract. UHS will arrange for payor's access to certain participating providers for the provision of transplant services. The benefit contracts covering transplant services, paid for pursuant to the agreement, must provide at least $500,000 in major medical coverage during a member's lifetime and must not require co-payments, coinsurance or deductibles from members in excess of a combined total of $10,000 for transplant services during any twelve-month period.

UHS will require participating providers to maintain and to require that all health care professionals employed by or under contract with participating providers maintain all federal, state and local licenses, certifications and permits necessary for the provision of transplant services.

COMPLIANCE WITH ALA. ADMIN. CODE 482-1-122

Health maintenance organizations are not required to comply with ALA. ADMIN. CODE 482-1-122 (2002). They are, however required to be in compliance with the federal privacy law by April 14, 2003.

The Company did not share customers' personal information with any nonaffiliated third parties. Any information the Company disclosed to any third parties was for the purpose of conducting day-to-day business functions such as the payment of claims.

Instructions were in place for employees to provide guidelines for the handling of personal information the Company employees or affiliated parties might have had access to.

The Company did provide notices to its customers that indicated the types of information it collected, the way it was used and the manner of collection. The notices also informed the customers that the Company did not disclose any information to any nonaffiliated third parties unless permitted to do so by law.

The Company's disclosure of any health information was made only after authorization from its customers unless the disclosures were made under section 17B of the NAIC model regulation.

ACCOUNTS AND RECORDS

General

The Company's accounting records were maintained primarily on electronic data processing (EDP) equipment. Certain detail records were maintained solely on microfiche and Company management maintained that certain records were not available in any form other than summary records.

Management and record-keeping functions were performed by personnel and facilities of United HealthCare Services, Inc. under various management and service agreements. Further discussion on the aforementioned agreements is included in the "HOLDING COMPANY AND AFFILIATE MATTERS" section under the caption *Transactions and Agreements with Affiliates*, on page 17 of this report.

The Company was audited annually by the independent certified public accounting (CPA) firm of Arthur Andersen, LLP, Minneapolis, Minnesota, for the two-year period covered by this examination. The CPA workpapers for 2000 and 2001 were not obtained from Arthur Andersen, LLP. The Company provided copies of some workpapers that they had in their possession from 2001. It is noted that effective May 16, 2002, Deloitte & Touche, LLP was appointed as the independent public accountant for United HealthCare of Alabama, Inc. replacing Arthur Anderson, LLP.

The reserve calculations for the examination period were certified by Thomas E. Burton, F.S.A., M.A.A.A., Senior Vice President and Chief Actuary of United HealthCare Insurance Company, an affiliate of the Company. The actuarial workpapers were provided from Connecticut and were not maintained in the Company's office in the State of Alabama, as is required by Section 15 of Alabama Department of Insurance Regulation Number 79.

With the exception of some network functions and sales, the Company had no operations in the state of Alabama. The examiners' contact person for this examination was located in Phoenix, Arizona. There were no accounting personnel or detailed accounting records located at the Company's home office. The Company's records were provided from various locations outside the state of Alabama. Alabama Department of Insurance Regulation Number 79 Section 15 requires that "...Every domestic HMO shall have and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind, or kinds, of business transacted..." "...Upon any removal or attempted removal of such records or assets outside this state beyond the period specified in the Commissioner's written consent under which the records were so removed or upon concealment of, or attempt to conceal, records or assets in violation of this regulation and Section 27-27-29 supra, the Commissioner shall institute delinquency proceedings against the HMO pursuant to the provisions of Sections 27-32-1 et seq. Code of Alabama 1975..."

Delinquency proceedings are defined in ALA. CODE § 27-32-1 (3) (1975) as "Any proceeding commenced against any insurer pursuant to this chapter for the purpose of liquidating, rehabilitating, reorganizing or conserving such insurer."

The Company routinely violated Alabama Department of Insurance Regulation Number 118 by not providing requested information to the examiners within ten working days.

Claim Processing Audits

During the examination period, the Company utilized two claims processing systems, COSMOS and UNET. On March 27, 2002, Arthur Andersen, LLP issued a report on the Uniprise UNET Claim Production. The report noted control and performance gaps and recommended solutions. Arthur Andersen issued a Network Data Management Follow-up Report on November 11, 2002 demonstrating that the Company took some corrective actions to comply with the recommendations.

It is noted that Arthur Andersen is no longer the Company's opining CPA firm; therefore, it is recommended that the Company require its current opining CPA firm to follow-up on the identified control and performance gaps to verify appropriate corrective action on all of the identified gaps and/or weaknesses.

Audits by Other Regulatory Agencies

United HealthCare of Alabama, Inc.'s 2000 and 2001 adjusted community rates (ACR) were audited by the Office of Inspector General (OIG) and PricewaterhouseCoopers, LLP, respectively. When the examiners requested the reports, the Company initially refused to provide them. Associate General Counsel of the Company provided a 2000 ACR audit final determination letter that was issued by the Department of Health and Human Services and the 2001 final determination letter issued by CMS along with an excerpt from the 2001 final report. The examiners reviewed these documents and determined that there could be both market conduct and financially significant issues discussed in these reports.

The examiners received a letter dated April 2, 2003 from a Company Compliance Manager which stated that "United's position is that the DOI does not have the legal authority to make any determinations or to review United's

compliance with the federal benefit setting process." The examiners also received a letter from Associate General Counsel of the Company, dated April 9, 2003, which stated that "...it is United's position that the state of Alabama does not have jurisdiction to review the OIG reports as part of its market conduct exam."

After the Alabama Commissioner of Insurance issued a letter to the Company on May 21, 2003 and held a meeting with the Company on June 3, 2003, the Company provided the requested information on June 3, 2003. The Company challenged the jurisdiction of the Alabama Department of Insurance to require it to submit the reports on the grounds that the State's requirement to submit those materials is pre-empted by federal law. The examiner disagreed with the Company's position as to pre-emption. The Company responded by submitting portions of the audit report to attempt to demonstrate that the issues raised in the reports were federal in nature. The Alabama Department of Insurance did not accept the legal argument and formally requested the documents again. In response to that request, the Company provided the documents.

It was determined that the 2000 and 2001 audit reports were not maintained at the Company's headquarters in Birmingham, Alabama in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

Other examination issues

In addition to the Company's violations (see "Issues," items 1 – 3 below) of ALA. CODE § 27-21A-16 (1975), Alabama Department of Insurance Regulation Number 118, and Alabama Department of Insurance Regulation Number 79 the immediately preceding Report of Examination was qualified because the Company did not provide all requested information to the examiners relating to the detail of premiums; receivable balances; and the subsequent collection thereof; and the documentation, reconciliation, support and/or status of certain claims paid/payable data as of December 31, 1999. The 1999 Report of Examination also cited the Company's lack of compliance

with Alabama Department of Insurance Regulation Number 118 and Alabama Department of Insurance Regulation Number 79.

Issue Number 1 – On February 4, 2003, the examiners requested all files pertaining to all claims benefits related litigation that was initiated between January 1, 2000 and December 31, 2001. On February 13, 2003, a Company Compliance Manager stated in an email "In response to your request for the file pertaining to all the litgations (sp) within the listing we provided, we are not able to provide you with complete access to the files, because the files contain attorney work product, as well as material subject to the attorney-client privilege." Without the litigation files, the examiners could not determine what liabilities may exist in relation to litigation. In addition, it was noted that the litigated claims files were located in Minnesota.

After the Alabama Commissioner of Insurance issued a letter to the Company on May 21, 2003 and held a meeting with the Company on June 3, 2003, the Company provided portions of the requested information.

Issue Number 2 – At December 31, 2002, the Company had no operations in Alabama except for 53 employees that relate primarily to network management and sales. None of these personnel were involved in the accounting, investment or claims functions of the Company. Items received from out-of-state included, but were not limited to the following:

Premium invoices and premium histories
Reinsurance contracts
Accounts receivable for uninsured A&H plans
Tax agreements and supporting workpapers
Surplus note approval letter
Capital stock ledger
General ledger details
Bank statements
Canceled checks
Conflict of interest statements
Valuation of Securities information, including SVO certification and PE security files.
Custodial agreements
Management agreements with external parties
Agents files
Complaints files
Reinstatement files

Litigated claims files
Outstanding check list

Issue Number 3 – In addition to the records not being located in Birmingham, Alabama, there are several instances cited within this report where the Company did not provide requested items. The number of items not provided to the examiners in their statistical samples was outside the parameters of an acceptable number of exceptions.

The more material instances of the Company not providing certain requested items are documented below. More in-depth discussion is included throughout this examination report:

Claims Payment Practices

Supporting documentation for 39 pharmacy claims

Bonds

Brokers Advices for 36 transactions made during 2001

Compliance with Agents' Licensing Requirement

Licenses and appointment forms for three commission-paid agents

Files for ten of the producers that were terminated during the examination period

45 of the requested 127 terminated producer files provided did not have any documentation supporting the termination.

Files containing the licenses and appointment forms for four policy-selling agents.

Policyholder complaints

Three complaint files

Claims unpaid

Documentation to support that claims payments were made according to contractual agreements for 21 of 47 claims sampled.

Claims files to support two of 47 unpaid claims sampled.

Canceled checks to support two of 47 unpaid claims sampled.

Claims files and documentation to support two large claim adjustments.

Reconciliation of claims payment to cash disbursements journal for four of 47 unpaid claims sampled.

Appropriate supporting detail (including policy level detail where applicable) for all amounts that composed $26,974,165 of $318,729,674 in claims paid recorded in the Underwriting and Investment Exhibit- Part 2B.

Out of a sample of 47 paid claims, the Company did not provide twelve.

Accrued Medical Incentive Pool and Bonus Payments

Contracts for providers who participated in the Medicare PCP (Primary Care Physician) Bonus payment program

SUMMARY:

ALA. CODE § 27-21A-16 (f) (1975), requires that "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner."

Alabama Department of Insurance Regulation Number 118 requires that: "The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

Alabama Department of Insurance Regulation Number 79 Section 15 requires that:

"An Alabama domiciled (domestic) HMO shall keep all necessary records in an Alabama location required for the efficient examination of its financial condition and health care delivery system. These records shall include but not be limited to the general ledger and subsidiary ledgers, management contracts, provider contracts, enrollment records, utilization records, group contract records, premium records, quality of care documentation records and complaint records..."

"Every domestic HMO shall have and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind, or kinds, of business transacted..."

"Upon any removal or attempted removal of such records or assets outside this state beyond the period specified in the Commissioner's written consent under which the records were so removed or upon concealment of, or attempt to conceal, records or assets in violation of this regulation and Section 27-27-29 supra, the Commissioner shall institute delinquency proceedings against the HMO pursuant to the provisions of Sections 27-32-1 et seq. Code of Alabama 1975..."

Delinquency proceedings are defined in ALA. CODE § 27-32-1 (3) (1975) as "Any proceeding commenced against any insurer pursuant to this chapter for the purpose of liquidating, rehabilitating, reorganizing or conserving such insurer."

FINANCIAL STATEMENTS INDEX

See Pages 97-99 for the Statement of Assets, Liabilities, Capital and Surplus, Statement of Revenue and Expenses, and Statement of Net Worth as reported by the Company in its filed Annual Statements.

EXAMINATION FINDINGS

The notes that follow represent items which indicated a violation of the Alabama Insurance Code, the Insurance Department's rules and regulations, or which were deemed to require comments and/or recommendations.

Note 1 - Bonds **$102,253,104**

The captioned asset is $260,417 less than the $102,513,521 reported by the Company in its 2001 Annual Statement.

The Company reported the NAIC designation of one bond with a book value of $260,417 as "2Z" in column 13 of *Schedule D - Part 1,* which indicated that the security had not been filed with the NAIC Securities Valuation Office (SVO). Alabama Department of Insurance Regulation Number 98 Section 2(A) requires that any security not valued in accordance with standards promulgated by the SVO be carried as a non-admitted asset until such time that the insurer has complied with the standards.

The Company indicated that a Security Acquisition Report (SAR) was not filed on this bond. This bond was purchased on March 14, 2001, at which time the Company had 120 days to file a SAR with the SVO. Utilizing this guideline, the examiners determined that the security should be non-admitted in accordance with Alabama Department of Insurance Regulation Number 98 Section 2(A).

The examiners were informed by the Company that there was no proof that the custodial agreement with Compass Bank, in force during the examination period, was approved by the Commissioner. After further investigation, the Alabama Department of Insurance confirmed that the custodial agreement with Compass Bank dated December 1996 was indeed approved. The Company did not have evidence of approval on file at its headquarters, which is in conflict with ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

A new agreement with Compass Bank was created and submitted to the Department for approval on April 21, 2003, and was approved April 30, 2003.

During the examination it was discovered that the Company did not file a SVO certification for the year 2000 as required in the NAIC Annual Statement Instructions for 2001:

"There is to be completed and attached to each quarterly and annual statement of the Company a certification that all requirements of the NAIC Securities Valuation Office (SVO) have been met in a timely fashion."

The Company is using a modified scientific method of amortization instead of the required scientific method, which is not in accordance with the NAIC Accounting Practices and Procedures Manual SSAP 26 Section 6 that states:

"Amortization of bond premium or discount shall be calculated using the scientific (constant yield) interest method taking into consideration specified interest and principal provisions over the life of the bond. Bonds containing call provisions (where the issue can be called away from the reporting entity at the issuer's discretion) shall be amortized to the call or maturity value/date which produces the lowest asset value (yield to worst)."

The Company adds the cost of accrued interest paid at purchase to the actual cost of the security in calculating effective yield. Effective yield is a key component in the Scientific Method Calculation. The NAIC Annual Statement Instructions provide that Book/Adjusted Carrying Value is to be calculated at:

"The original cost of acquiring the bond, including brokerage and other related fees, to the extent they do not exceed the fair market value at the date of acquisition. Amortization of premium or accrual of discount, but not including any accrued interest paid thereon."

During the examination period, the Company did not maintain complete documentation concerning its investment transactions, including the preservation of all brokers' advices received from the investment institution making transactions on behalf of the Company, as required by ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal

place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

It was also noted that the Company was unable to provide sampled brokers' advices in a timely manner. The first request for the brokers' advices was made on March 26, 2003. The Company was only able to provide five of the 47 brokers' advices. Six of the 47 sampled brokers' advices were paydowns on securities so there were no brokers' advices. This failure to provide the sampled broker's advices is a violation of Alabama Department of Insurance Regulation Number 118, Section 6, which states: "The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

Note 2 - Cash **$23,624,376**

The captioned amount is the same as reported in the Company's 2001 Annual Statement. It was noted that the Company's Regions Bank reconciliation did not include the -$792.00 account balance located in the zero balance account that is tied to the Regions Checking account. This amount was immaterial so no adjustment needs to be made to the financials contained in the report.

It was noted that the Company collected premiums for its UNET system in Chicago, IL and Newark, NJ at United HealthCare Insurance Company. The premiums are remitted to United HealthCare of Alabama, Inc. with intercompany settlements that occur throughout the month. It was also noted that the Company collects its past due premiums in Lake Mary, Florida. The Company should not allow funds to be deposited outside of the state of Alabama nor should the premiums be routed to a lockbox that is not owned and controlled by United HealthCare of Alabama, Inc. The Company is in violation of ALA. CODE § 27-21A-6 (c) (1975), which requires that "Any officer, or director, or any member of any committee or any employee of a health maintenance organization who is charged with the duty of investing or handling the organization's funds shall not deposit or invest such funds except in the organization's corporate name..." The Company is also in violation of ALA. CODE § 27-27-29 (b) (1975), which states that "Every domestic insurer shall have, and maintain, its assets in this state..."

In reconciling the total interest received to the Underwriting and Investment Exhibit, Part 4 of the 2001 Annual Statement, the examiners discovered that the Company had neglected to include on the Schedule E, interest that had

been received from two US Treasury Bills. This interest totaled to $6,076.00 and was included in the Underwriting and Investment Exhibit, Part 4, Page 15, Column 1, Line 5.1 of the 2001 Annual Statement.

The examiners requested a listing of the outstanding checks as of December 31, 2001. This request was sent on February 6, 2003. On February 17, 2003, the examiners received the listing in microfiche format, but the Company had no machine on site to print out or read the information in this format. On April 17, 2003, the examiners received a hard copy of the listing. The listing consisted of 524 pages of information. It was determined that UnitedHealth Group, Incorporated receives an electronic copy of the outstanding check list, which is reconciled with the bank statement. UnitedHealth Group, Incorporated then keeps one copy of the outstanding check list in Hartford Treasury in Connecticut, and one copy at Health Plan Accounting in Minnesota, both in microfiche format. The examiners found that the outstanding checks are not kept in electronic format by the Company. The list of outstanding checks was being stored in the form of microfiche, which makes the information very difficult and time consuming to recover. The Company does not have, nor can they create an electronic copy of the outstanding checklist.

It was also noted that the information took more than ten days to be sent to the examiners and that the list is being maintained outside of the state of Alabama. The delay in receiving the information constitutes a violation of Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

The list of outstanding checks not being maintained in the state of Alabama constitutes a violation of ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

Note 3 - Accident and Health Premiums Due and Unpaid $0

The captioned amount is $415,046 less than the $415,046 reflected in the Company's 2001 Annual Statement. The following schedule represents the premium receivable asset, at December 31, 2001, and the examination adjustment:

	Per the Company	Per the Examination
Premium Receivables	$4,527,513	$2,504,617
Premium Receivables (over 90 days)	1,576,781	3,599,677
Total Premium Receivables	6,104,294	6,104,294
Premium Clearing account	-1,026,621	-1,026,621
Not admitted premiums over 90 days	-1,576,781	-3,599,677
Allowance for doubtful accounts	-3,085,847	-1,477,996
Premium Receivable admissible	$ 415,046	$ 0

The examiners determined that the Company had receivables over ninety days in the amount of $3,599,677. Per the Company's 2001 Annual Statement, the Company only non-admitted $1,576,781. The examiners noted that the Company did not non-admit all premium balances over ninety days in accordance with the SSAP No. 6, paragraph 9. This issue was also addressed in the previous two examination reports.

Instead of non-admitting the entire $3,599,677 as required by SSAP No. 6, the Company only non-admitted $1,576,781 and maintains that they included the remaining $2,022,896 in their "Allowance for doubtful accounts." The total that the Company established for its allowance for doubtful accounts was $3,085,847.

The Company did not provide the examiners with supporting documentation that reconciled to the $3,085,847 Allowance for doubtful accounts. Therefore, the examiners:

1.) Non-admitted the entire $3,599,677 in premiums that was over 90 days.
2.) Reduce the allowance for doubtful accounts to $1,477,996 in order to not bring the admitted balance of premiums due and unpaid below zero.

It was determined that the Company did not keep complete records of its premiums receivable. It was also determined that the premium receivable data sets were not maintained at the Company's headquarters in Birmingham,

Alabama. The Company was not in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

Note 4 - Healthcare Receivables **$0**

The captioned amount is the same as reported in the Company's 2001 Annual Statement.

It was determined by the examiners that the Company had loaned $130,000 to Radiologist PC. This money was to be paid back to the Company in 13 consecutive equal monthly installments of $10,000 beginning on December 10, 2000. It was determined that no interest was charged on the loan. The Director of Network Management explained that the purpose for the loan was that at that time United Healthcare was struggling to pay Radiologist PC's claims according to their contract and the group was threatening to cancel their contract which would have resulted in a "gap." Another email from the Director of Network Management stated that the group's contract was non-standard and there was difficulty programming the reimbursement structure into the claims system.

Note 5 - Amounts recoverable from reinsurers **$80,815**

The captioned amount is the same as reported in the Company's 2001 Annual Statement.

The examiners reviewed United HealthCare Insurance Company's (UHIC) 2001 Annual Statement to confirm the reinsurance recoverable directly. It was noted that UHIC did not record a payable at year-end 2001 while United HealthCare of Alabama recorded a receivable of $80,815.

Note 6 - Amounts due from parent, subsidiaries, and affiliates **$222,516**

The captioned amount is the same as reported in the Company's 2001 Annual Statement. In the previous examination report, the examiners noted that the Company netted all affiliate settlements through United HealthCare

Corporation's Intercompany Clearing Segment. In the Intercompany Settlement Clearing Segment, all intercompany settlements are centralized through a clearing segment. The clearing segment is used to net the multiple intercompany payable and receivable obligations for each entity into a single balance. NAIC Annual Statement Instructions stipulate that amounts due to or from affiliates can be offset and reported net. However, receivables and payables must be reported separately if amounts are due from different affiliates in accordance with guidelines established in the NAIC Accounting Purposes and Procedures Manual.

Note 7 - Amounts receivable relating to uninsured accident and health plans **$0**

The captioned amount is $250,024 less than the $250,024 amount reported by the Company in its 2001 Annual Statement.

It was determined by the examiners that the Company recorded receivables from affiliates for the University of Alabama at Birmingham (UAB) in the amounts receivable relating to uninsured accident and health plans line item. Per the Vice President of Finance, UAB was an uninsured plan for which the membership and revenue resided on United HealthCare Management Company. During 2001, the Company paid claims on behalf of United HealthCare Management Company for UAB with UAB providing reimbursement to the Company. Since UAB was not a group of the Company, the entire balance of $236,195 was non-admitted.

It was noted that the Company recorded receivables for Birmingham News in the accounts receivable relating to uninsured accident and health plans line item. However, Birmingham New was a fully insured group. The balance appearing in the uninsured plans related to supplemental coverage for Birmingham News. The Company was paying the deductibles for Birmingham News' executives and Birmingham News was reimbursing the Company back for the deductibles that were paid. This balance of $13,829 was non-admitted because there were no formal arrangements for the Company to pay the deductibles.

It was noted that the Company did not maintain the detail for its uninsured plans, therefore not complying with Section 15 of Alabama Department of Insurance Regulation Number 79 which states:

"...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind, or kinds, of business transacted..."

The Company was also in violation of ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner."

Note 8 - Receivable for securities **$34,600**

The captioned amount is the same as reported by the Company in its 2001 Annual Statement. It was determined by the examiners that the Company had recorded money market cash interest payments due and accrued in the Receivables/Payables for Securities Account. According to the NAIC Annual Statement Instructions for Health Insurance Companies, contents of this account should include, "amounts received within 15 days of the end of the period that are due from brokers when a security has been sold, but the proceeds have not yet been received." The interest payments should have been recorded in the Investment income due and accrued line item. The amount recorded as a receivable was immaterial.

Note 9 - Federal and foreign income tax recoverable **$2,815,545**

The captioned amount is the same as reported in the Company's 2001 Annual Statement.

It was noted that the Company included the total change in net deferred tax along with the total current federal income tax provision as income tax provision on the statutory statement of operations. The total change in net deferred tax should have been reversed out of the income statement and netted against retained earnings/surplus in accordance with SSAP No. 10, paragraph 7. Per SSAP No. 10, paragraph 7, "Changes in deferred tax assets and deferred tax liabilities, including changes attributable to changes in tax rates and changes in tax status, if any, shall be recognized as a separate component of gains and losses in unassigned funds (surplus)..."

Note 10 - Claims unpaid **$47,580,808**

The captioned amount is the same as reported in the Company's 2001 Annual Statement. During the review of the unpaid claims liability, the Company provided policy level detail and general ledger detail in order to validate the amount of the liability. The policy level detail was provided from the Company's two claims processing systems, COSMOS and UNET. In requesting the detail, one of the fields that was to be included in the datasets was the check issued dates. For the COSMOS detail, the Company did not include the check issued dates in the dataset. For the UNET detail, the Company did include the check issued dates in the dataset. After selecting a sample from the 2001 unpaid claims detail and reconciling to the payments made in 2002, the examiners found that some of the claims sampled had paid dates before December 31, 2001. Because the detail from both claims processing systems did not include the check issued dates, the examiners were unable to determine the amount that the liability was overstated. The examiners did determine that the claims liability in relation to the UNET claims processing system was overstated by $10,703.

Also during the review of the unpaid claims liability, the examiners selected a sample of 47 items from the claims detail in order to verify the accuracy of the detail with the claims files and trace the payments made in 2002 to the cash disbursements journal and canceled checks. For two of the UNET claims sampled, the check issue dates from the claims detail were not consistent with dates found on the canceled checks.

The examiners also noted that the Company did not maintain any documentation to support the unpaid claims liability at its home office in Birmingham, Alabama. This problem was noted in the preceding examination report issued by the Alabama Department of Insurance.

During the review of the claims paid during 2001, the examiners requested policy level detail to support the amount of paid claims reported in the Underwriting and Investment Exhibit, Part 2B, columns 1 and 2, line 11. Of the $318,729,674 of paid claims reported, the Company did not provide appropriate supporting detail (including policy level detail where applicable) for all amounts that composed $26,974,165. The Company provided general ledger activity to support this amount. The preceding report of examination noted this same problem.

After reconciling the 2000 and 2001 general ledger activity and paid claims detail from the COSMOS and UNET claims processing systems to the 2000 and 2001 Annual Statements, the examiners scanned the general ledger activity and detail for any unusual amounts (i.e. large claim payments and large claim adjustments). From scanning the ledger activity and claims detail, the examiners found and requested the detail to support 43 claims. These 43 claims were significantly higher than the other claims payments and claims adjustments in the general ledger and claims detail. The Company was unable to provide supporting documentation for two of the 43 claims requested within ten business days in accordance with the Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

The examiners also noted that the Company did not maintain any documentation to support the amount of claims paid at the home office in Birmingham, Alabama. The preceding report of examination noted this same problem.

In a separate procedure, the examiners selected a sample of 47 claims in order to verify that the payments were made in accordance with the contractual terms between the Company and provider or pharmacy. The examiners requested claims files and payment schedules in order to verify that the amounts of the payments were according to the contractual agreements. The examiners found the following for the 47 items sampled:

- For 26 of 47 claims sampled, the Company was able to provide payment schedules to show how much the Company paid per procedure and/or service based on the physicians contracted rates.
- There was one pharmacy claim adjustment in which the Company was unable to provide any supporting documentation.
- The other twenty claims sampled were pharmacy claims. The Company has an agreement with United Healthcare Services to provide administrative services relating to pharmacy management and claims processing for its enrollees. United Healthcare Services contracts with Merck-Medco Managed Care for provision of these services. The Company provided screen prints from Medco to show the calculation of each claim payment. The examiners obtained the Pharmacy Benefit

Management Agreement between United HealthCare Services and Merck Medco Managed Care, L.L.C. as well as group contracts for the enrollees included in the sample. The payment of claims, according to the Pharmacy Benefit Management Agreement, Financial Appendix, Section 1, is based on one of the three scenarios:

"United HealthCare will pay PBM(Medco) for covered Prescription Drug in an amount equal to the lowest of the following minus covered Person's Co-payment: (a) the pharmacy's usual and customary price, as submitted, (b) the maximum allowable cost, where applicable plus dispensing fee, or (c) the network's applicable AWP (average wholesale price) minus discount plus dispensing fee."

The amount paid to PBM by United HealthCare Services, Inc. is the amount that PBM pays on behalf of the Company for pharmacy claims. In order to determine that claims were being paid according to the contract, the examiners first determined the amount of co-payment by reviewing the certificate of coverage for each group sampled. Next the examiners were to calculate amounts for (a), (b), and (c) from the contracts language and determine which amount was the least. The Company was unable to provide all information needed to figure the amounts for scenarios (b) and (c). Therefore the examiners were unable to determine if these payments were made according to contractual terms.

The examiners also selected another sample of 47 claims from the unpaid claims detail. The examiners used this sample in order to reconcile information provided in the unpaid claims detail to the actual claim files and canceled checks. The Company provided the claims files for 45 of the 47 items sampled. The two outstanding claims were pharmacy claims. The Company has an agreement with United Healthcare Services (UHS) to provide administrative services relating to pharmacy management and claims processing for its enrollees. United Healthcare Services contracts with Merck-Medco Managed Care (Medco) to pay all pharmacy claims for the health care plans under United Healthcare Services. Since Medco is contracted to pay the pharmacy claims for UHS as well as other nonaffiliated health care providers, Medco's claims payments to individual pharmaceutical companies is grouped together for all health care providers with whom they have contracts. Therefore, the Company contends that it would be too much trouble to track these claims in order to provided canceled checks. The Company was not able to provide the claims files and canceled checks in order for the examiners to

verify the claimed amounts, policy number, provider name and code, service code, line of business, dates of service, claim received date, claimed amount paid and date from the database. Failure to provide information necessary for the examination is a violation of Alabama Department of Insurance Regulation Number 118, Section 6 which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

The examiners asked how the Company can prove to a claimant that a pharmacy claim has been paid if the Company was unable to provide the examination team with the requested documentation. The Company should have a database or the ability to query a database by policyholder and/or claim amount that ties back into specific "batch" payments which ultimately ties back into a canceled check or wire transfer. Without the ability to do this, the Company does not have the ability to vouch its payments for pharmaceutical claims to any outside source.

For the two outstanding pharmacy claims, the examiners were informed by the Company contact that "Given the amount of time it will take to pull the requested documentation to indicate how the pharmacy claim payments tie to the United HealthCare general ledger, we [the Company] will not be providing the sample items requested. As was noted during the conference call, United HealthCare pays Medco for all pharmacy claims; Medco in turn pays the pharmacies. United HealthCare maintains pharmacy claims payment data can be used to prove to Medco that a pharmacy claim has been paid. Medco maintains pharmacy claims payment data that can be used to prove to a pharmacy that a pharmacy claim has been paid."

Also for the sample above, the examiners were to trace the claims payment into the cash disbursements journal. Of the 47 items sampled, 43 items were sampled from the COSMOS claims processing system and four items were sampled from the UNET claims processing system. For the four items sampled from the UNET claims processing system, the Company was unable to provide any documentation from within the cash disbursements journal of the payment of these four claims.

The previous examination recommended that the Company maintain all detailed information supporting the claims paid and claims payable reported in

Schedule H of its future financial statements. This recommendation has been made again during the current examination.

Note 11 - Accrued Medical Incentive Pool **$35,000**

The captioned amount is the same as reported in the Company's 2001 Annual Statement. The examiners reviewed the General Interrogatories to verify the completeness of the information disclosed. Line 9.1 of the General Interrogatories- Part 2 in the 2001 Annual Statement states that the Company had bonus/withhold arrangements in its provider contracts. The examiners requested a copy of the Medicare PCP bonus agreement between the Company and the participating providers. The examiners were informed that only fee for service primary care physicians (PCP) participated in this bonus program at the discretion of the Company and there is not a contractual arrangement. The examiners note that because the Company was unable to provide a contractual agreement, the examiners could not determine if an adequate amount for this liability was established or if the Company was paying only the appropriate providers.

During the review of the Medicare PCP bonus program, the examiners were to select a sample of provider contracts to ensure that withhold percentages and calculations were in accordance with provisions contained in the contracts. The Company does not have a contractual agreement with the providers who participate in the Medicare PCP bonus program but paid $2 per member per month for servicing Medicare members. The Company did not provide a report as of December 31, 2001, to verify the number of Medicare members serviced during the fourth quarter 2001. The report that was provided was as of June 25, 2003, which included additional members serviced since December 31, 2001 for some of the participating physicians. Therefore, the examiners were unable to verify the actual number of Medicare members serviced during the fourth quarter 2001 for all of the physicians sampled. The examiners also found that the fourth quarter report did not include one of the 47 participating physicians sampled. The examiners noted that the Company terminated the physician from the report in error and provided documentation to show that the provider's membership with the Company was in effect as of December 31, 2001.

On June 5, 2003, the examiners requested a detailed listing of providers with whom the Company had withhold or medical incentive pool arrangements under the Physician Incentive Allowance (PIA) agreement in 2000 in order to ensure that withhold percentages and calculations were in accordance with

provisions contained in the contract. On July 28, 2003, the examiners were provided the listing of physicians who participated in the PIA agreement during 2000. The PIA agreement was terminated on January 1, 2001. Because the listing was not provided in an adequate enough time to select a sample, request information to accomplish the procedure, and review the detail provided before the completion of the examination, the examiners were unable to accomplish the procedure. The failure to provide the information within 10 working days was a violation of the Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

Note 12 - Premiums received in advance **$19,445,231**

The captioned amount is the same as reported by the Company in its 2001 Annual Statement.

The examiners requested a sample of 47 premiums received in advance on March 13, 2003. The Company provided a response that stated that six of the 47 groups were billed individually. The Company provided three of the six individually billed groups because the groups did not have many individuals within the group. The examiners received a response on April 7, 2003 that stated that the Company was not going to provide the other three individually billed groups because it would take an extraordinary amount of work to provide the auditable details requested. On May 30, 2003, the examiners received the requested items. The Company did not comply with ALA. CODE § 27-2-23(b) (1975), which states: "Every person being examined, its officers, attorneys, employees, agents and representatives, shall make freely available to the Commissioner or his examiners the accounts, records, documents, files, information, assets and matters in his possession or control relating to the subject of the examination."

In addition, the Company was not in compliance with Alabama Department of Insurance Regulation Number 118, Section 6, which states "The insurer shall provide, within ten (10) working days, any records or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

The Company also made a cash application error. The Company recorded an amount in an Alabama account that was actually a Mississippi account. However, the amount was properly reversed and applied correctly to a Mississippi legal entity. See "Premium Allocation Agreement" – Page 19 for a related discussion.

Note 13 - General expenses due or accrued **$661,688**

The captioned amount is the same as reported in the Company's 2001 Annual Statement. A payment to Balch and Bingham LLP, made on January 7, 2002 and invoiced on October 19, 2001, was not recorded in this line item for 2001. This transaction was recorded in the general ledger on the date that it was paid. Company management indicated that "Legal fees that are not covered by insurance are not accrued for because of the relatively low dollar volume. These legal fee invoices are processed and reflected on the general ledger in the month they are paid." The amount of this transaction was deemed to be immaterial.

See "Commitments and Contingent Liabilities" – Page 69 for related discussion.

Note 14 – Unassigned funds (surplus)

See Pages 97-99 for the financial statements of the Company, as reported in the Annual Statements filed with the Alabama Department of Insurance.

COMMITMENTS AND CONTINGENT LIABILITIES

At December 31, 2001, the Company accrued $1,400,000 for settlements on two outstanding cases. These amounts were included in Claims Unpaid on the 2001 Annual Statement because these cases were provider claim disputes. There were no other amounts accrued.

Company management indicated that "Legal fees resulting from the following litigation are covered by insurance and would require no accruals on the health plans general ledger. Medical Malpractice (direct and vicarious) Breach of Duty benefit disputes (cost to defend and extra damages, if applicable). Provider disputes (cost to defend and extra damages, if applicable). Legal fees resulting from the following litigation are not covered by insurance. employment

matters regulatory matters. Because of the relatively low dollar volume, the Company does not accrue legal fees for these types of litigation. The invoices are processed and reflected on the general ledger in the month they are paid."

While the examiners acknowledge that legal fees have not routinely been a material amount, the preceding report of examination specifically recommended that the Company reserve for expenses of litigation on lawsuits known to exist at the Annual Statement reporting date. Therefore, the Company did not comply with this recommendation. Company management responded that they accrue known, material liabilities at year-end and that it was their opinion that these types of fees were generally not known or material.

All legal invoices were maintained and provided from Golden Valley, Minnesota. The examiners requested (in writing) legal invoices on April 18, 2003 and they were provided May 7, 2003.

In addition, the examiners reviewed the legal invoices and determined that the documentation provided did not demonstrate that 42 of the 58 payments made in 2001 and 16 of the 27 made in 2002 actually were the responsibility of United HealthCare of Alabama. The examiners again requested adequate supporting documentation on May 9, 2003. Additional information (which confirmed multiple errors in payments made in 2001 and 2002) was provided on August 1, 2003.

ALA. CODE § 27-21A-16 (f) (1975), requires that "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner."

Alabama Department of Insurance Regulation Number 118 requires that "The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

Alabama Department of Insurance Regulation Number 79 Section 15 requires that: "An Alabama domiciled (domestic) HMO shall keep all necessary records in an Alabama location required for the efficient examination of its financial condition and health care delivery system. These records shall include but not be limited to the general ledger and subsidiary ledgers, management contracts, provider contracts, enrollment records, utilization records, group contract records, premium records, quality of care documentation records and complaint records..." "Every domestic HMO shall have and maintain, its

principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary or suitable as to the kind, or kinds, of business transacted..." "Upon any removal or attempted removal of such records or assets outside this state beyond the period specified in the Commissioner's written consent under which the records were so removed or upon concealment of, or attempt to conceal, records or assets in violation of this regulation and Section 27-27-29 supra, the Commissioner shall institute delinquency proceedings against the HMO pursuant to the provisions of Sections 27-32-1 et seq. Code of Alabama 1975..." Delinquency proceedings are defined in ALA. CODE § 27-32-1 (3) (1975) as "Any proceeding commenced against any insurer pursuant to this chapter for the purpose of liquidating, rehabilitating, reorganizing or conserving such insurer."

In addition, the Director of Risk Management, UnitedHealth Group, Inc., represented that "United HealthCare Services pays insured legal expenses for the Health Plan." Uninsured expenses (generally provider fees and benefit costs as well as regulatory matters and employment liability) are charged to the Health Plan. United HealthCare of Alabama does not pay legal costs for insured matters. Those invoices are paid by United HealthCare Services. Since United HealthCare Services pays the costs reference [sp] above, payments made by insurers are reimbursed to United HealthCare Services."

This practice results in the Company's books and records not accurately reflecting its legal expenses. United HealthCare Services is purchasing insurance for the expenses of the Company and then collecting those insurance proceeds instead of those transactions flowing through the accounts and records of the Company. H&W Indemnity, Ltd. is a Cayman Islands affiliate of the Company and is one of the insurers that United HealthCare Services is purchasing insurance from. The Company did not provide the examiners with evidence that H&W Indemnity is approved to write business on any kind of basis in the United States.

In addition, it was noted that, contrary to representations by the Director of Risk Management, employed by UnitedHealth Group, Inc., the Company paid certain expenses that should have been covered by the insurance policies purchased by UnitedHealth Services.

The pleadings were maintained and provided from Edina, Minnesota by Associate General Counsel for UnitedHealthcare, A UnitedHealth Group Company.

The litigation files that were provided were redacted. Associate Counsel for the Company stated that "it was agreed that United HealthCare of Alabama would submit certain litigation documents but would redact any data protected by the attorney-client or work product privileges. The redacted information would be identified in a privilege log. We have supplied the information from litigation files in response to the Department's request, and decline to disclose the redacted information because it is privileged. Explanations of why these documents are considered privileged have been supplied by counsel in a separate e-mail." The Company's editing of their litigation files went beyond the examiners' expectations and included the redaction of "work done under the direction of legal counsel in preparation for the litigation" and communications to its liability carrier.

The examiners requested and received letters from outside counsel. The firm of Weil, Gotshal & Manges LLP, New York, NY disclosed a case that was not disclosed by Company management or by Company Counsel. The letter identified a nation-wide class action lawsuit that could have implications for the Company. It does not appear that the Company is named directly in the lawsuit; however, United Healthcare, Inc. and UnitedHealthGroup Incorporated are named. The plaintiffs, which are health care providers that have contractual relationships with at least one or more of eight defendant managed care companies, allege ten causes of action against the defendants generally arising out of the manner in which physicians are reimbursed for their services. The claims include multiple violations of RICO, claims for benefits under ERISA, breach of contract, Medicare Prompt Payments laws, unjust enrichments, and violation of state prompt payment statutes. The allegations to support RICO claims include allegations of mail and wire fraud, ERISA kickbacks, extortion and violation of the Travel Act.

Associate General Counsel for the Company provided the examiners with a listing of benefits-related litigation that arose between January 1, 2000 and December 31, 2001.

The following differences were noted between Associate General Counsel's listing and the pleadings provided:

1.) The Graves Settlement was settled for approximately $4600 more than the $2500 disclosed by the Company's attorney.
2.) The Powell case settled for $500 more than the $4600 disclosed by the Company's attorney.

3.) The Nix case settled for $1093 more than the $1000 disclosed by the Company's attorney.
4.) The Harvey case settled for $1000 more than the $1526 disclosed by the Company's attorney. The $1000 was to cover Ms. Harvey's legal fees.

The examiners received a response from the Company's Deputy General Counsel, on February 17, 2003. The response was deemed incomplete because the Deputy General Counsel failed to provide the present status of each identified case and an opinion on the amount and probability of ultimate payment of each item. We sent a follow up to the Deputy General Counsel on February 27, 2003. We received a revised response from the Deputy General Counsel on April 11, 2003. This response included additional information including status and opinion on the amount and probability of ultimate payment on each case. Also, he added certain Medicare-related litigation that was originally "inadvertently omitted" and he deleted one case because the Company filed suit and wasn't being sued.

Cases disclosed by the Deputy General Counsel with differing information included:

Brown – The Deputy General Counsel indicated a little over $2,000 - the file reflected claims payments of $3,178.50. The Deputy General Counsel did not provide a reason for the discrepancy; however, Associate General Counsel stated that "it appears that there were two separate claims paid: the hospital claim for $2084, which was the claim at issue in the suit, and then a related claim, subsequently demanded by the doctor, for $1094. The Company's files indicated that these claims were settled at the same time with the same documents.

Neither Associate General Counsel nor Deputy General Counsel's listing included the Mobile Infirmary case and settlement. Associate General Counsel initially responded that "Mobile Infirmary was not included on my list because it was not a benefit-related suit (it was a dispute revolving around the provider contract). It was not included on Tim's list, because it settled prior to December 31, 2001." The examiners' review of the Company's file indicated that the settlement agreement was dated December 14, 2001. The Company was in violation of the settlement agreement at December 31, 2001 because the settlement was not paid until January 2002. The case was not dismissed until January 28, 2002. Associate General Counsel then responded that it was the

Company's interpretation that we didn't want any cases other than benefit-related lawsuits. We provided her with the e-mail which requested "The listing of litigated claims should be a list of all benefit-related suits filed by either enrollees or providers. If these are two different listings, please provide both." Associate General Counsel did not provide any additional information.

In addition, neither Associate General Counsel nor Deputy General Counsel disclosed an arbitration award against the Company in March 2001, which resulted in the Company paying $3,145,000. This was identified by the examiners when investigating a significant variance in the legal expenses for the year 2001.

The examiners requested that the Company provide, as originally requested, a listing of all litigation. This was requested on May 8, 2003. After a meeting with the Alabama Department of Insurance Commissioner, the Company provided the examiners with a listing of litigation that the Company's General Counsel represented was complete.

The pleadings were maintained and provided from Edina, Minnesota.

SUBSEQUENT EVENTS

It was noted that the Company hired Dr. Evangeline R. Franklin, M.D. on February 24, 2003 with the intent that she would serve as the Medical Director in Alabama. On March 3, 2003, the Board of Directors elected Ms. Franklin as the Medical Director to replace Dr. Larry B. Amacker, M.D. In May 2003, it was noted that Dr. Franklin was not qualified to serve as the Medical Director in Alabama. On the date the board officially appointed her as the Alabama Medical Director, Dr. Franklin was not a licensed Alabama physician nor had she applied for such license. Dr. Franklin was only licensed in Louisiana. The Alabama Department of Public Health Rule Number 420-5-6.11(2)(a) requires that the Company's medical director hold an Alabama license or have an application on file at the time of her appointment. On May 12, 2003, the Board of Directors reversed the election and reinstated Dr. Larry Amacker, M.D. until Dr. Franklin obtains her license in Alabama.

Dividends:

It was noted that the Company declared dividends in the amount of $32.8 million and $39 million on July 15, 2002 and April 10, 2003, respectively.

Changes in administration:

The Company transferred its commercial consumer affairs research and resolution function to an Ohio office, effective April 1, 2002. The Company also transferred its Medicare appeals and grievance function to Tampa, Florida.

The following COSMOS functions were transferred from Lake Mary, Florida to Duluth, Minnesota in March and April 2003.

-Eligibility (Member Enrollment)
-Billing and Support
-Case Installations

On March 11, 2003, Mr. Charles C. Pitts notified the Corporation that he shall resign as Chairman, President and Chief Executive Officer of the Corporation effective June 30, 2003. On May 27, 2003, Mr. T. David Lewis was elected to serve as Chairman, President and Chief Executive Officer of the Corporation effective July 1, 2003.

On July 21, 2003, the Company's Medicare related customer service functions were relocated to the Medicare service center in Sunrise, Florida.

On July 28, 2003, the Company's National Appeals Service Center relocated its Southeast Region Complaints/Grievances function from Dayton, Ohio to Duluth, Minnesota. The Department of Insurance Complaints will also relocate to Duluth, Minnesota on or around December 8, 2003.

COMPLIANCE WITH PREVIOUS RECOMMENDATIONS

A review was conducted during the current examination with regard to the Company's compliance with recommendations made in the previous examination report. This review indicated that the Company had not satisfactorily complied with the prior recommendations as listed below:

Bonds - In the previous exam, it was recommended that the Company maintain complete records of its assets, transactions and affairs in accordance with Section 15 of Alabama Department of Insurance Regulation Number 79 and ALA. CODE § 27-21A-16(f) (1975). It was also noted that a similar recommendation was made in the exam preceding that exam. Failure to comply with this recommendation was evident in the Company's failure to provide the complete sample of brokers' advices. It was also evident in the

Company's failure to provide proof of the Compass Bank custodial agreement approval by the Alabama Department of Insurance. The Company originally said that the agreement was not approved because they could find no proof of the approval in their records. The examiners requested information from the Alabama Department of Insurance and determined that the agreement was approved.

Cash and short-term investments - It was noted in the last exam that the Company was using several bank accounts located in other states. The Chase Manhattan Bank is based out of New York, New York. During the exam period, the Company used this account for claims payment clearing and premium receipt. The final check written on the Chase account was on August 28, 2000, but wire transfers of premiums to this account continued until December 31, 2002. Balances per the bank statements at December 31, 2001, amounted to $0.00. Also the account statements for all accounts, except for the Compass Custodial Statement, were received from outside the state. This account remaining active, along with the majority of the bank account statements being kept in Minnesota, continues to represent a violation of ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

Accident and health premiums due and unpaid - The Company did not non-admit all account balances ninety days past due in accordance with the NAIC Accounting Practices and Procedures Manual.

The Company did not maintain all detailed information supporting the premium receivable amount reported in its 2001 Annual Statement. The Company could not provide all detail for its premium clearing account.

The Company did not maintain complete records supporting the premium receivable amounts at its Alabama home office in accordance with Section 15 of Alabama Department of Insurance Regulation Number 79.

Amounts due from parent, subsidiaries and affiliates - In the previous examination report, the examiners noted that the Company netted all affiliate

settlements through United HealthCare Corporation's Intercompany Clearing Segment. In the Intercompany Settlement Clearing Segment, all intercompany settlements are centralized through a clearing segment. The clearing segment is used to net the multiple intercompany payable and receivable obligations for each entity into a single balance. NAIC Annual Statement Instructions stipulate that amounts due to or from affiliates can be offset and reported net. However, receivables and payables must be reported separately if amounts are due from different affiliates in accordance with guidelines established in the NAIC Accounting Purposes and Procedures Manual.

Federal income taxes recoverable - The Company did not maintain supporting records for its taxes in its Alabama home office in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

Claims Unpaid - The Company did not maintain any documentation to support the unpaid claims liability at its home office in Birmingham, Alabama. This recommendation was made in the previous examination issued by the Alabama Department of Insurance.

In the preceding examination, it was recommended that the Company maintain all detailed information supporting the claims paid and claims payable reported in Schedule H of its future financial statements. This recommendation has been made again during the current examination.

During the review of the claims paid during 2001, the examiners requested policy level detail to support the amount of paid claims reported in the Underwriting and Investment Exhibit, Part 2B, columns 1 and 2, line 11. Of the $318,729,674 in paid claims reported, the Company did not provide appropriate supporting detail (including policy level detail where applicable) for all amounts that composed $26,974,165. The Company only provided general ledger activity to support this amount. The items in question were not related to specific policies and policy level detail was not applicable; however, the Company did not provide supporting documentation for the general ledger entries. This recommendation was made in the previous examination report.

The Company did not maintain any documentation to support the paid claims at its home office in Birmingham, Alabama. This recommendation was made in the previous examination report issued by the Alabama Department of Insurance.

COMMENTS AND RECOMMENDATIONS

The following summary presents the comments and recommendations that are made in the current *Report of Examination.*

Committees – Page 5

It is recommended that the Company only appoint directors to serve on committees of the Board of Directors as required by ALA. CODE § 10-2B-8.25 (1975), which states that:

"...a Board of Directors may create one or more committee and appoint members of the Board of Directors to serve on them. Each committee may have one or more members, who serve at the pleasure of the Board of Directors."

Holding Company – Data Ownership – Page 10

It is recommended that the Company require that the data ownership agreement between United Healthcare Services and Unysis, and the data ownership agreement between Metra Health (now known as United HealthCare Insurance Company) and Integrated Systems Solutions Corporation be amended to name United Healthcare of Alabama as the sole owner of its data.

Holding Company and Affiliate Matters – Page 10

It is recommended that management at the Company review all related party agreements before they become effective to insure that the terms and conditions of the agreement are fair and reasonable to the Company.

Transactions and Agreements with Affiliates – Page 17

It is recommended that the Company maintain all approved service agreements with all affiliated companies that provide any service for the

Company as required by Alabama Department of Insurance Regulation Number 79 Section 13, paragraph 3, which states "Any management contractor who shall manage the financial affairs, investment affairs or any of the health care activities of the HMO shall be subject to prior approval by the Commissioner with the advice of the State Health Officer. In no instance shall the Board of Directors of the HMO relinquish the right to dismiss the management contractor for failure to perform his required duties."

It is recommended that the Company submit for approval to the Commissioner of the Alabama Department of Insurance, the Tax Sharing Agreement, and the Subordinated Revolving Credit Agreement as required by ALA. CODE § 27-21A-2(c)(3) and (d)(1) (1975) and Alabama Department of Insurance Regulation Number 79 Section 13, which states "Any management contractor who shall manage the financial affairs, investment affairs or any of the health care activities of the HMO shall be subject to prior approval by the Commissioner with the advice of the State Health Officer."

It is recommended that the Company halt all activity related to the Premium Allocation Agreement as it is in violation of ALA. CODE § 27-21A-6(c) (1975), which requires that "Any officer, or director, or any member of any committee or any employee of a health maintenance organization who is charged with the duty of investing or handling the organization's funds shall not deposit or invest such funds except in the organization's name..."

Fidelity Bond and Other Insurance – Page 28

It is recommended that the Company keep the records of its fidelity bond and other insurance coverage at its headquarters in Birmingham, Alabama in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

Territory – Page 30

It is recommended that the Company properly report in its Annual Statements all territories where it is allowed to operate.

Policy Forms and Underwriting Practices – Page 32

It is recommended that the Company properly maintain all of its reinstatement files to have access to those files whenever needed. These records should be kept and organized for examination purposes as required by Alabama Department of Insurance Regulation Number 79 Section 15, which requires that: "... Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions and affairs..."

It is recommended that the Company provide all documents requested by the examiners within ten days as required by Alabama Department of Insurance Regulation Number 118, Section 6, which requires: "The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner. When the requested record or response is not produced or cannot be produced by the insurer within ten working days, the nonproduction shall be deemed a violation of this rule, unless the Commissioner or duly appointed person making the request grants an extension in writing or the insurer can demonstrate to the satisfaction of the Commissioner that there is a reasonable justification for the delay."

Advertising and Marketing – Page 33

It is recommended that the Company not include any ambiguous or misleading information in any of its form letters, and not use any other names except for its corporate name that was approved by the Commissioner, in accordance with ALA. CODE § 27-21A-13 (d) (1975), which requires that

"No health maintenance organization unless licensed as an insurer may refer to itself as a licensed insurer or use a name deceptively similar to the name or description of any insurance or surety corporation doing business in this state."

and Alabama Department of Insurance Regulation Number 79 Section 12 states "No name other than that approved by the Commissioner may be used. The name of the HMO may not be changed without prior approval of the Commissioner. Any name which is misleading as to the purpose or type of organization or which is deceptively similar to the name of another licensed HMO shall not be used by the HMO."

It is also recommended that the Company not instruct its customers to send their premiums to any entities outside the state of Alabama, which is not in compliance with ALA. CODE § 27-21A-6 (c) (1975), which requires that

"Any officer, or director, or any member of any committee or any employee of a health maintenance organization who is charged with the duty of investing or handling the organization's funds shall not deposit or invest such funds except in the organization's corporate name..." ALA. CODE § 27-27-29 (1975) requires that "Every domestic insurer shall have, and maintain, its assets in this state..."

Claims Payment Practices – Page 35

It is recommended that the Company keep all records pertaining to its claims at its headquarters or in a location approved by the Commissioner as required by ALA. CODE § 27-21A-16 (f) (1975), which states that:

"All records necessary for the complete examination of the health maintenance organization domiciled organization domiciled in this state shall be maintained in a location approved by the Commissioner."

It is recommended that the Company not delay the sending of claim checks after the paid date.

It is recommended that the Company not impose any limits on mental health benefit services that are not imposed on medical and surgical services in compliance with ALA. CODE § 27-54-4 (b) (1) (1975), which stipulates that:

"The group health benefit plan shall offer to provide benefits for the treatment and diagnosis of mental illnesses under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illnesses"

It is recommended that the Company provide information requested by any duly appointed deputy, assistant, employee or examiner of the Commissioner of the Alabama Department of Insurance in accordance with Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

Treatment of Members and Claimants – Page 35

It is recommended that the Company properly include a requirement in its complaint handling procedures indicating that complaints received through the Department must be responded to within ten days in accordance with Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

and Alabama Department of Insurance Bulletin dated January 31, 1963, which states:

"The Department of Insurance henceforth will take the position that an insurance company must answer both the policy holder and this Department within ten days after receipt of a departmental complaint."

Compliance With Agents' Licensing Requirements – Page 40

It is noted that the Company paid commissions to agencies not licensed in the state of Alabama totaling $2,451.92.

It is recommended that the Company keep the necessary detail on the commissions paid to its producers and comply with ALA. CODE § 27-7-35.1 (1975), which states:

"(a) An insurance company or insurance producer shall not pay a commission, service fee, brokerage, or other valuable consideration to a person for selling, soliciting, or negotiating insurance in this state if that person is required to be licensed under this chapter and is not so licensed.

(b) A person shall not accept a commission, service fee, brokerage, or other valuable consideration for selling, soliciting, or negotiating insurance in this state if that person is required to be licensed under this chapter and is not so licensed.

(c) Renewal or other deferred commissions may be paid to a person for selling, soliciting, or negotiating insurance in this state if the person was required to be licensed under this chapter at the time of the sale, solicitation, or negotiation and was so licensed at that time.

(d) An insurer or insurance producer may pay or assign commissions, service fees, brokerages, or other valuable consideration to an insurance agency or to persons who do not sell, solicit, or negotiate insurance in this state, unless the payment would violate chapter 12 of this title.

(e) Any insurer or producer violating this section shall be liable for a fine in an amount of up to three times the amount of the commission paid. The fine shall be levied and collected by the commissioner. Upon failure to pay the fine the commissioner may, in his or her discretion, revoke the license of the producer or the insurer's certificate of authority, or both."

It is recommended that the Company either maintain all producer records at its headquarters in the state of Alabama or obtain Commissioner authorization to move the records out of state. This should be done to comply with ALA. CODE § 27-21A-16 (1975), which requires that:

"All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15, which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

and ALA. CODE § 27-8-24 (c) (1975), which requires that:

"Upon termination of the appointment of an agent, or as soon thereafter as possible, and immediately upon completion of the insurer's investigation, the insurer shall file with the Commissioner a written statement of the facts relative to the termination and the date and cause thereof..."

Rate Filings – Page 43

It is recommended that the Company properly maintain it records relating to the small group rate filings in accordance with Ala. Admin. Code 482-1-116 Section .05 (g) (2) (2002) which requires that: "Each small employer carrier shall file with the Commissioner annually on or before March 15, both of the following:
a. An actuarial certification certifying that the carrier is in compliance with this regulation... A copy of the certification shall be retained by the small employer carrier at its principal place of business."

Reinsurance – Page 44

It is recommended that the Company submit its general liability and reinsurance policies to the Commissioner with each annual report in accordance with the Alabama Department of Insurance Regulation Number 79 Section 14.

It is recommended that the Company evaluate its exposure and potential need for additional reinsurance coverage due to issuing policies to its members with no stated maximum benefits.

It is recommended that the Company provide requested information in accordance with Alabama Department of Insurance Regulation Number 118, Section 6, which states that "The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner..."

Accounts and Records – Page 46

It is recommended that the Company require that its CPA firm make available for review all workpapers prepared in the conduct of their examination and any communication related to the audit between the CPA firm and the Company in accordance with the NAIC Annual Statement Instructions.

It is recommended that the Company provide all information requested by the examiners as required in Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner. When the requested record or response is not produced or cannot be produced by the insurer within ten working days, the nonproduction shall be deemed a violation of this rule, unless the Commissioner or duly appointed person making the request grants an extension in writing or the insurer can demonstrate to the satisfaction of the Commissioner that there is a reasonable justification for the delay."

It is recommended that the Company not retain information outside the State of Alabama in accordance with the Alabama Department of Insurance Regulation Number 79 Section 15, which states:

"Removal of all, or a material part thereof, the records or assets of an Alabama domiciled HMO except pursuant to a plan of merger or consolidation approved by the Commissioner, or concealment of such records or assets, or material part thereof, from the Commissioner is prohibited. Upon any removal or attempted removal of such records or assets or upon retention of such records or assets, or material part thereof, outside this state beyond the period specified in the Commissioner's written consent under which the records were so removed or upon concealment of, or attempt to conceal, records or assets in violation of this regulation and Section 27-27-29 supra, the Commissioner shall institute delinquency proceedings against the HMO pursuant to the provisions of Sections 27-32-1 et seq. Code of Alabama 1975."

It is recommended that the Company require its current opining CPA firm to follow-up on identified control and performance gaps to verify appropriate corrective action on all of the identified gaps and/or weaknesses.

Bonds – Page 55

It is again recommended that the Company value its bonds in accordance with the Purposes and Procedures Manual of the NAIC Securities Valuation Office and Alabama Department of Insurance Regulation Number 98. **It is further recommended** that bonds not valued in accordance with standards promulgated by the SVO be carried as non-admitted assets until such time as the Company has complied with said standards.

It is recommended that the Company keep the records of custodial agreements at its headquarters in Birmingham, Alabama in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..." A similar recommendation was made in the previous examination report.

It is recommended that the Company properly complete and attach to each quarterly and annual statement a SVO certification which is required in the NAIC Annual Statement Instructions for 2001:

"There is to be completed and attached to each quarterly and annual statement of the Company a certification that all requirements of the NAIC Securities Valuation Office (SVO) have been met in a timely fashion."

It is recommended that the Company use the scientific method to amortize bonds as required by SSAP No. 26, paragraph 6 which requires that:

"Amortization of bond premium or discount shall be calculated using the scientific (constant yield) interest method taking into consideration specified interest and principal provisions over the life of the bond. Bonds containing call provisions (where the issue can be called away from the reporting entity at the issuer's discretion) shall be amortized to the call or maturity value/date which produces the lowest asset value (yield to worst)."

It is also recommended that the Company not include the cost of accrued interest in the calculation of book value as required by the NAIC Annual Statement Instructions.

It is recommended that the Company provide information requested by any duly appointed deputy, assistant, employee or examiner of the Commissioner of the Alabama Department of Insurance in accordance with Alabama Department of Insurance Regulation Number 118, Section 6, which states: "The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

Cash - Page 57

It is recommended that the Company include all balances in this line item both positive and negative in accordance with the NAIC Annual Statement Instructions for 2001.

It is recommended that the Company comply with ALA. CODE § 27-21A-6(c) (1975), which states:

"Any officer, or director, or any member of any committee or any employee of a health maintenance organization who is charged with the duty of investing or handling the organization's funds shall not deposit or invest such funds except in the organization's corporate name..."

It is also recommended that the Company comply with ALA. CODE § 27-27-29 (b) (1975), which states:

"Every domestic insurer shall have, and maintain, its assets in this state..."

It is recommended that the Company record all interest received from investments in the appropriate schedules in its Annual Statements.

It is recommended that the Company receive, from UnitedHealth Group Incorporated, the outstanding checks in electronic format and maintain a listing of outstanding checks in electronic format.

It is recommended that the Company provide information requested by any duly appointed deputy, assistant, employee or examiner of the Commissioner of the Alabama Department of Insurance in accordance with Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

It is recommended that the Company keep the records of its investment transactions, including the preservation of outstanding check lists, at its headquarters in Birmingham, Alabama in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

Accident and health premiums due and unpaid – Page 59

It is recommended that the Company maintain complete records supporting its premiums receivable at its headquarters in Birmingham, Alabama in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall

have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

It is recommended that the Company non-admit all receivables over ninety days in accordance with SSAP No. 6, paragraph 9.

It is recommended that the Company keep supporting documentation for the calculation of its allowance for doubtful accounts.

Healthcare receivables – Page 60

It is recommended that the Company charge a fair and reasonable amount of interest when loaning money to health care providers.

Amounts recoverable from reinsurers – Page 60

It was noted that United HealthCare of Alabama recorded a receivable at year-end 2001 and United HealthCare Insurance Company did not establish a payable for $80,815 at year-end 2001.

It is recommended that the Company not establish receivables from affiliates if related liabilities are not established by affiliates.

Amounts due from parent, subsidiaries, and affiliates – Page 60

It is recommended that the Company record receivables and payables separately if amounts are due from or to different affiliates, in accordance with the guidelines established in the SSAP No. 64 of the NAIC Accounting Practices and Procedures Manual.

Amounts receivable relating to uninsured accident and health plans – Page 61

It is recommended that the Company not pay claims on behalf of United HealthCare Management Company without a formal agreement.

It is recommended that the Company not pay deductibles for its groups without a formal agreement.

It is recommended that the Company keep the records of its uninsured plans in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

Receivable for securities – Page 62

It is recommended that the Company only classify amounts as "Receivable for securities" when the asset meets the requirement of the NAIC Annual Statement Instructions for this line item.

Claims unpaid – Page 63

It is recommended that the Company's unpaid claim liability include claims that have not been paid as of the Annual Statement date in accordance with SSAP No. 55, paragraph 6 of the NAIC Accounting Practices and Procedures Manual.

It is recommended that the Company maintain all detailed information including claims files, canceled checks and cash disbursement transactions supporting each claim included in the claims liability recorded in the Underwriting and Investment Exhibit- Part 2A of its Annual Statements.

It is recommended that the Company provide information requested by any duly appointed deputy, assistant, employee or examiner of the Commissioner of the Alabama Department of Insurance in accordance with Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

It is recommended that the claims detail provided to support the unpaid claims liability be consistent with the claims information in the Company's claims files.

It is recommended that the Company keep the records of its unpaid and paid claims at its headquarters in Birmingham, Alabama or in a location approved by the Commissioner in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and the Alabama Department of Insurance Regulation Number 79 Section 15 which requires that "... Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

It is recommended that the Company maintain supporting documentation, including policy-level detail where applicable, to support each paid claim recorded in the Underwriting and Investment Exhibit- Part 2B of its Annual Statements.

It is recommended that the Company provide information requested by any duly appointed deputy, assistant, employee or examiner of the Commissioner of the Alabama Department of Insurance in accordance with Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

Accrued Medical Incentive Pool and Bonus Payments – Page 67

It is recommended that the Company create a contract for the Medicare Primary Care Physicians (PCP) bonus program detailing the specifics and conditions of the program.

It is recommended that the Company maintain all documentation to support the amount of quarterly Medicare PCP bonus payments.

It is recommended that the Company provide information requested by any duly appointed deputy, assistant, employee or examiner of the Commissioner of the Alabama Department of Insurance in accordance with Alabama Department of Insurance Regulation Number 118, Section 6, which states:

"The insurer shall provide, within ten (10) working days, any record or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

Premiums Received in Advance – Page 68

It is recommended that the Company comply with ALA. CODE § 27-2-23(b) (1975), which states "Every person being examined, its officers, attorneys, employees, agents and representatives, shall make freely available to the Commissioner or his examiners the accounts, records, documents, files, information, assets and matters in his possession or control relating to the subject of the examination."

It is recommended that the Company comply with Alabama Department of Insurance Regulation Number 118, Section 6, which states "The insurer shall provide, within ten (10) working days, any records or response requested in writing by any duly appointed deputy, assistant, employee or examiner of the Commissioner."

General expenses due or accrued – Page 69

It is recommended that the Company record all expenses in the Annual Statement for the year in which they are incurred.

It is again recommended that the Company reserve for expenses of litigation on lawsuits known to exist at the Annual Statement reporting date.

Commitments and Contingent Liabilities – Page 69

It is again recommended that the Company reserve for expenses of litigation on lawsuits known to exist at the Annual Statement reporting date.

It is recommended that the Company provide any record or response requested in writing by the Alabama Department of Insurance within ten working days as required by Alabama Department of Insurance Regulation Number 118.

It is recommended that the Company keep all necessary records in an Alabama location that are required for the efficient examination of its financial condition and health care delivery system as required by Alabama Department of Insurance Regulation Number 79 Section 15.

It is recommended that the Company move its operations back to Alabama and maintain its principal place of business and home office in this state and keep therein complete records of its assets, transactions and affairs as required by Alabama Department of Insurance Regulation Number 79 Section 15.

It is noted that Alabama Department of Insurance Regulation Number 79 Section 15 also specifies that: "Upon any removal or attempted removal of such records or assets outside this state beyond the period specified in the Commissioner's written consent under which the records were so removed or upon concealment of, or attempt to conceal, records or assets in violation of this regulation and Section 27-27-29 supra, the Commissioner shall institute delinquency proceedings against the HMO pursuant to the provisions of Sections 27-32-1 et seq. Code of Alabama 1975..." Delinquency proceedings are defined in ALA. CODE § 27-32-1 (3) (1975) as "Any proceeding commenced against any insurer pursuant to this chapter for the purpose of liquidating, rehabilitating, reorganizing or conserving such insurer."

It is recommended that the Company's books and records accurately reflect its legal expenses instead of those expenses being paid by affiliated entities.

Furthermore, **it is recommended** that the Company maintain documentation that when insuring risks, either directly or through affiliates, that those risks are insured with entities that are approved to write business in the appropriate jurisdictions of the United States.

It is recommended that the Company not pay legal expenses that should be covered by insurance policies purchased by or through UnitedHealth Services.

Subsequent Events – Page 74

It is recommended that the Company comply with the Alabama Department of Public Health Rule Number 420-5-6.11(2)(a), which requires that the Company's Medical Director have a physician's license in the State of Alabama.

Compliance with previous recommendations – Page 75

It is again recommended that the Company keep the records of its brokers' advices and approved custodial agreements at its headquarters in Birmingham, Alabama in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health

maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

It is again recommended that the Company non-admit all account balances ninety days past due in its future financial statements in accordance with the NAIC Accounting Practices and Procedures Manual.

It is again recommended that the Company maintain all detailed information supporting the premium receivable amount reported in its 2001 Annual Statement.

It is again recommended that the Company maintain complete records supporting the premium receivable amounts at its Alabama home office or in a location approved by the Commissioner in accordance with Section 15 of Alabama Department of Insurance Regulation Number 79.

It is again recommended that the Company record receivables and payables separately if amounts are due from or to different affiliates, in accordance with the guidelines established in the SSAP No. 64 of the NAIC Accounting Practices and Procedures Manual.

It is again recommended that the Company keep the records of its unpaid claims at its headquarters in Birmingham, Alabama or in a location approved by the Commissioner in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and the Alabama Department of Insurance Regulation Number 79 Section 15 which requires that "... Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

It is again recommended that the Company maintain all detailed information including claims files, canceled checks and cash disbursement transactions to support each claim included in the claims liability recorded in the Underwriting and Investment Exhibit- Part 2A of its Annual Statements.

It is again recommended that the Company maintain all policy level detail to support the paid claims reported in the Underwriting and Investment Exhibit-Part 2B of its Annual Statements.

It is again recommended that the Company keep the records of its paid claims at its headquarters in Birmingham, Alabama or in a location approved by the Commissioner in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and the Alabama Department of Insurance Regulation Number 79 Section 15 which requires that "... Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

It is again recommended that the Company keep the records of its bank account activity at its headquarters in Birmingham, Alabama or in a location approved by the Commissioner in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

It is again recommended that the Company keep the records of its taxes at its headquarters in Birmingham, Alabama or in a location approved by the Commissioner in accordance with ALA. CODE § 27-21A-16 (f) (1975), which requires that: "All records necessary for the complete examination of a health maintenance organization domiciled in this state shall be maintained in a location approved by the Commissioner." and Alabama Department of Insurance Regulation Number 79 Section 15 which requires that: "...Every domestic HMO shall have, and maintain, its principal place of business and home office in this state and shall keep therein complete records of its assets, transactions, and affairs..."

CONCLUSION

The customary insurance examination procedures as recommended by the National Association of Insurance Commissioners have been followed to the extent appropriate and possible in connection with this examination.

In addition to the undersigned, Anne Ogle, Tisha Freeman, Douglas Moseley, and Shaun Sori, Examiners; and Joe Wallace, ASA, Consulting Actuarial Examiner, all representing the Alabama Department of Insurance, participated in this examination of United HealthCare of Alabama, Inc.

Respectfully submitted,

James L. Hattaway, III, CFE
Examiner-in-Charge
State of Alabama Department of Insurance

February 17, 2004

ADDENDUM

The examiners provided the standard NAIC Representation Letter to the following officers/individuals representing United HealthCare of Alabama for their signature: T. David Lewis, President, Christina R. Palme-Krizak, Secretary, Robert W. Oberrender, Treasurer, Rhonda R. Bagby, Vice President – Finance, and Carolyn Callopy-Mora, Market Conduct Examination/ Assessment Team Manager.

Without consultation with the examiners or disclosure to the examiners, the Company modified the representation letter to:

1.) Limit the time period covered by their representation to January 1, 2000 to December 31, 2001 instead of January 1, 2000 to August 13, 2003.
2.) Remove Christina R. Palme-Krizak, Robert W. Oberrender, and Carolyn Callopy-Mora from the representation letter.

STATEMENT OF ASSETS, LIABILITIES, SURPLUS AND OTHER FUNDS
For the Year Ended December 31, 2001
AS REPORTED BY UNITED HEALTHCARE OF ALABAMA, INC. IN FILED ANNUAL STATEMENTS

ASSETS	Assets	Nonadmitted Assets	Net Admitted Assets
Bonds	$ 102,513,521		$ 102,513,521
Cash and short-term investments	25,382,135		25,382,135
Receivable for securities	34,600		34,600
Accident and health premiums due and unpaid	1,991,826	1,576,781	415,045
Health care receivables	284,872	284,872	
Amounts recoverable from reinsurers	80,815		80,815
Investment income due and accrued	1,604,185		1,604,185
Amounts due from parent, subsidiaries and affiliates	222,516		222,516
Amounts receivable relating to uninsured accident and health plans	262,414	12,390	250,024
Federal and foreign income tax recoverable	2,815,545		2,815,545
Other receivables	62,000		62,000
Prepaids	266,344	266,344	-
TOTAL ASSETS	**$ 135,520,773**	**$ 2,140,387**	**$ 133,380,386**

LIABILITIES	Covered	Uncovered	Total
Claims unpaid	$ 43,022,567	$ 4,558,241	$ 47,580,808
Accrued medical incentive pool and bonus payments	35,000		35,000
Aggregate claim reserves	791,673		791,673
Premiums received in advance	19,445,321		19,445,321
General expenses due or accrued	661,688		661,688
Federal and foreign income tax payable	5,549,060		5,549,060
Amounts withheld or retained by company	83,458		83,458
Other payables	297,947		297,947
TOTAL LIABILITIES			**$ 74,444,955**
SURPLUS			
Common capital stock	XXX	XXX	$ 101,978
Preferred capital stock	XXX	XXX	20,000
Gross paid in and contributed surplus	XXX	XXX	17,561,870
Less 15,000 shares treasurery stock at cost	XXX	XXX	(56,250)
Unassigned funds (surplus)	XXX	XXX	41,307,833
Surplus as regards policyholders			**$ 58,935,431**
TOTAL LIABILITIES AND SURPLUS			**$ 133,380,386**

STATEMENT OF REVENUE AND EXPENSES
For the Year Ended December 31, 2001
AS REPORTED BY UNITED HEALTHCARE OF ALABAMA, INC. IN FILED ANNUAL STATEMENTS

REVENUES		
Net premium income	$	394,789,266
Aggregate write-ins for other health care related revenues		-
Total Revenues	$	394,789,266
MEDICAL AND HOSPITAL		
Hospital/medical benefits	$	309,179,607
Other professional services		76,844
Aggregate write-ins for other medical and hospital		(1,880,024)
Incentive pool and withhold adjustments		39,455
Subtotal	$	307,415,882
Less:		
Net reinsurance recoveries	$	1,140,116
Total medical and hospital		306,275,766
Claims adjustment expenses		13,806,765
General administrative expenses		30,160,737
Total underwriting deductions	$	350,243,268
Total underwriting gain or (loss)	$	44,545,998
Net investment income earned	$	6,106,498
Net realized capital gains or (losses)		399,272
Net investment gains or (losses)	$	6,505,770
Aggregate write-ins for other income or expenses	$	14,916
Net income or (loss) before federal income taxes	$	51,066,684
Federal and foreign income taxes incurred		18,299,513
Net income (loss)	$	32,767,171

STATEMENT OF NET WORTH
For the Years Ended December 31, 1999, 2000 and 2001
AS REPORTED BY UNITED HEALTHCARE OF ALABAMA, INC. IN FILED ANNUAL STATEMENTS

	1999	2000	2001
Net worth beginning of year	$ 2,945,572	$ 13,468,027	$ 30,196,005
Increase (decrease) in paid in surplus	-	9,500,000	-
Net income	5,830,930	6,906,008	32,767,171
Change in nonadmitted assets	4,691,522	321,970	2,796,134
Change in surplus notes			(1,000,000)
Cumulative effect of changes in accounting principles			44,630
Dividends to stockholders			(5,748,508)
Aggregate write-ins for changes in other net worth items	3	-	(120,000)
Net worth end of year	$ 13,468,027	$ 30,196,005	$ 58,935,432

DON SIEGELMAN
GOVERNOR

STATE OF ALABAMA
DEPARTMENT OF INSURANCE
201 MONROE STREET, SUITE 1700
POST OFFICE BOX 303351
MONTGOMERY, ALABAMA 36130-3351
TELEPHONE: (334) 269-3550
FACSIMILE: (334) 241-4192
INTERNET: www.aldoi.org

D. DAVID PARSONS
COMMISSIONER
ASSISTANT COMMISSIONER
TREY GRANGER
DEPUTY COMMISSIONER
JAMES R. (JOHNNY) JOHNSON
CHIEF EXAMINER
RICHARD L. FORD
STATE FIRE MARSHAL
JOHN S. ROBISON
GENERAL COUNSEL
MICHAEL A. BOWNES
RECEIVER
DENISE B. AZAR
LICENSING MANAGER
JIMMY W. GUNN

September 24, 2002

Mr. Jack A. Wickens
President
United Healthcare of Alabama, Inc.
3700 Colonnade Parkway
Birmingham, AL 35243

Re: Financial/Market Conduct Examination As Of December 31, 2001

Dear Mr. Wickens:

This letter is to inform you of a financial/market conduct examination of your company called by the Alabama Department of Insurance and to authorize James L. Hattaway, CFE, Examiner, to conduct the examination. This authorization is pursuant to the instructions of Alabama Insurance Commissioner, D. David Parsons, and in compliance with the statutory requirements of the State of Alabama and resolutions adopted by the National Association of Insurance Commissioners. The NAIC has required as an accreditation standard that examination reports be issued within eighteen (18) months of the "as of" date of the examination. This is requiring us to begin the examinations earlier to meet this requirement.

Your examination is to commence on or about November 4, 2002, and will be conducted primarily in your offices. The expected duration of the examination is approximately six months. Preliminary planning of your examination will first begin in the offices of the Alabama Department of Insurance. The examiner will arrive in your offices on or after this date. You will be contacted by Mr. Hattaway regarding the exact arrival date at your offices.

The Alabama Insurance Department has adopted work policies and rules governing work hours, leave and unacceptable conduct including sexual harassment. If you have any question about our examiner's conduct at your offices, please contact me immediately.

As part of your examination, the enclosed internal control and information systems questionnaire is required to be completed for review by our examiner. Please complete and return the questionnaire to this Department within 30 days, addressed to the attention of the Examiners' Division. The questions may be answered on the questionnaire itself or on a separate sheet if additional explanation is required. If possible, your CPA's workpapers and a representative of your CPA firm should be available the week of November 4, 2002, for review at your offices.

Invoices covering examination fees and related expenses will be submitted to the appropriate company official in accordance with standard Departmental policy. Payment of any examination charges so invoiced are due within two business days following presentation of the invoice.

Sincerely,

Richard L. Ford, CFE, CIE
Acting Deputy Commissioner and
Chief Examiner

RLF:dk

Enclosures

cc: Jack M. Brown, CFE, CIE
James L. Hattaway, CFE, Examiner-in-Charge
LaShonda Moultrie, Analyst

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Jack A. Wickens
President
United Healthcare of Alabama Inc
3700 Colonnade Parkway
Birmingham, AL 35243

COMPLETE THIS SECTION ON DELIVERY

A. Received by *(Please Print Clearly)* CMASON B. Date of Delivery 9-26-02

C. Signature X CMason ☐ Agent ☐ Addressee

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number *(Copy from service label)*
7099 3400 0015 2327 6064

PS Form 3811, July 1999 Domestic Return Receipt 102595-00-M-0952

DON SIEGELMAN
GOVERNOR

STATE OF ALABAMA
DEPARTMENT OF INSURANCE
201 MONROE STREET, SUITE 1700
POST OFFICE BOX 303351
MONTGOMERY, ALABAMA 36130-3351
TELEPHONE: (334) 269-3550
FACSIMILE: (334) 241-4192
INTERNET: www.aldoi.org

D. DAVID PARSONS
COMMISSIONER
ASSISTANT COMMISSIONER
TREY GRANGER
DEPUTY COMMISSIONER
JAMES R. (JOHNNY) JOHNSON
CHIEF EXAMINER
RICHARD L. FORD
STATE FIRE MARSHAL
JOHN S. ROBISON
GENERAL COUNSEL
MICHAEL A. BOWNES
RECEIVER
DENISE B. AZAR
LICENSING MANAGER
JIMMY W. GUNN

September 24, 2002

Mr. Glen Taylor
Taylor-Walker & Associates, Inc.
Actuarial Consulting Group
P. O. Box 156
40 North Main
Midvale, UT 84047

Re: Market Conduct/Financial Examination of United Healthcare of Alabama, Inc.

Dear Mr. Taylor:

This letter is to request and authorize your participation in the examination of the above referenced company for the purpose of computing reserves and making other valuations in your usual manner.

The examination is scheduled to begin on or about November 4, 2002. The examination for this company is being conducted in the company's offices at 3700 Colonnade Parkway, Birmingham, AL 35243, and will cover the period of time ending December 31, 2001. The expected duration of the examination is approximately six months. The company's telephone number is (205) 977-6300.

The Examiner-in-Charge will be Mr. James L. Hattaway. Please contact him at the company after the beginning date to coordinate the scheduling of your portion of this examination.

If your schedule does not permit you to accept this assignment, please let me know so that other arrangements can be made.

Thank you for your assistance in this matter.

Sincerely,

Richard L. Ford, CFE, CIE
Acting Deputy Commissioner and
Chief Examiner

RLF:dk
cc: Jack M. Brown, CFE, CIE
James L. Hattaway, Examiner-in-Charge
LaShonda Moultrie, Analyst

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Glen Taylor
Taylor-Walker & Associates Inc
Actuarial Consulting Group
P O Box 156
40 North Main
Midvale UT 84047

COMPLETE THIS SECTION ON DELIVERY

A. Received by *(Please Print Clearly)* KR

B. Date of Delivery 9-30

C. Signature

X LaVon Taylor ☐ Agent ☐ Addressee

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☒ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number *(Copy from service label)*
7099 3406 0015 2327 6019

PS Form 3811, July 1999 Domestic Return Receipt 102595-00-M-0952

11-6-02

UnitedHealthcare

A UnitedHealth Group Company

UnitedHealthcare Alabama
AL001-1001 P.O. Box 836037 Birmingham AL 35283-0637

October 24, 2002

Mr. Richard Ford, CFE, CIE
Acting Deputy Commissioner & Chief Examiner
Alabama Department of Insurance
201 Monroe Street, Suite 1700
P.O. Box 303351
Montgomery, Alabama 36130-3351

RE: Financial/Market Conduct Examination As of December 31, 2001

Dear Mr. Ford:

We received your letter dated September 24, 2002. Enclosed please find the completed planning and information systems questionnaires. The responses to the planning questionnaire include references to attachments that are also enclosed.

Our Health Plan Accounting Department would also like to begin pulling claims data as soon as possible in order to avoid time delays during the audit. We would appreciate your auditors providing us the parameters such as date ranges, data fields, etc., as soon as possible so that we can begin extracting the data.

Please call me at 1-800-264-3639 ext 237 when you determine the date that we can expect to have your examiner on site at our Birmingham, Alabama, location. Let me know if you require additional information.

Sincerely,

Rhonda R. Bagby
Vice President, Finance

Copies without attachments sent to:
Jack M. Brown, CFE, CIE, AL Department of Insurance
James L. Hattaway, CFE, Examiner-in-Charge, AL Department of Insurance
LaShonda Moultrie, Analyst, AL Department of Insurance
Copies with planning questionnaire responses (no IS questionnaire) sent to:
Charles C. Pitts, CEO, UnitedHealthcare of Alabama
Jean Boord, UnitedHealthcare Compliance
Paula Guthrie, UnitedHealthcare Compliance

UnitedHealthcare
A UnitedHealth Group Company

UnitedHealthcare of Alabama Inc.
Post Office 830637 Birmingham AL 35283-0637

August 20, 2003

James L. Hattaway, III
Examiner-In-Charge
Alabama Department of Insurance
PO Box 303350
Montgomery, AL 36130-3350

We are providing this letter in connection with your examination of the statutory financial statements of United HealthCare of Alabama, Inc. as of December 31, 2001, and for the period from January 1, 2000 to December 31, 2001. We are responsible for the preparation in the statutory financial statements of financial position, results of operations, and changes in statutory financial position in conformity with the accounting practices prescribed or permitted by the Alabama Department of Insurance.

Certain representations in this letter are described as being limited to those matters that are material. Solely for the purpose of preparing this letter, the term "material," when used in this letter, means any item or group of similar items involving potential amounts of more than $500,000. These amounts are not intended to represent the materiality threshold for financial reporting and disclosure purposes. Notwithstanding this, an item is considered material, regardless of size, if it involves an omission or misstatement of accounting information that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would have been changed or influenced by the omission or misstatement.

We confirm, to the best of our knowledge and belief, the following representations made to you during the examination.

1. We have made available to you all:

   Statutory financial records and related data; and

   Minutes of meetings of stockholders, directors, and committees of directors, or summaries of actions of recent meetings for which minutes have not yet been prepared.

2. There has been no:

   Fraud or other irregularities involving management or employees who have significant roles in the internal control structure;

   Fraud or other irregularities involving other employees that have or may have a material effect on the statutory financial statements;

Fraud or other irregularities involving agents, MGA's, third party administrators, independent contractors, holding companies or other individuals or parties that have or may have a material effect on the statutory financial position of the Company; or

Communications from regulatory agencies concerning noncompliance with, or deficiencies in, statutory financial reporting practices. This includes those related to Medicare and Medicaid antifraud and abuse statutes.

3. We have no plans or intentions that may materially affect the carrying value or classification of assets and liabilities.

4. The financial statements are free of material and intentional immaterial misstatements.

5. The following have been properly recorded or disclosed in the statutory financial statements:

Any related party transactions and related amounts receivable or payable, including sales, purchases, loans, transfers, leasing arrangements, and guarantees.

All liabilities, both actual and contingent.

Guarantees whether written or oral, under which the company is contingently liable.

Capital Stock repurchase options or agreements on capital stock reserved for options, warrants, conversions, or other requirements.

Arrangements with financial institutions involving compensating balances or other arrangements involving restrictions on cash balances and line-of-credit or similar arrangements.

Significant estimates and material concentrations known to management that are required to be disclosed in accordance with SSAP No. 1, *Disclosure of Accounting Policies, Risks & Uncertainties, and Other Disclosures.*

Amount of credit risk and extent, nature, and terms of financial instruments with off-balance-sheet risk to be disclosed in accordance with SSAP No. 27.

Agreements to repurchase assets previously sold.

6. We confirm the completeness of the information provided regarding the identification of related parties.

7. There are no violations or possible violations of laws or regulations whose effects should be considered for disclosure in the statutory financial statements or as a basis for recording a loss contingency. This includes those related to Medicare and Medicaid antifraud and abuse statutes, including but not limited to the Medicare and Medicaid anti-Kickback Statutes, Limitations on Certain Physical Referrals (the Stark law), and the False Claims Act, in any jurisdiction, whose effects should be considered for disclosure in the financial statements or as a basis for recording a loss contingency other than those disclosed or accrued in the financial statements.

8. Billings to third party payors comply in all material respects with diagnostic and procedure coding guidelines (for example ICD-9-CM and CPT-4) and laws and regulations (including those dealing with Medicare and Medicaid antifraud and abuse), and billings reflect only charges for goods and services that were medically necessary; properly approved by regulatory bodies (i.e. Food and Drug Administration), if required and properly rendered.

9. Contingent Liabilities:

There are no other liabilities or gain or loss contingencies that are required to be accrued or disclosed by SSAP No. 5.

There is no litigation against the Company that is considered material in relation to the statutory financial position of the Company. For purposes of this section, the company has excluded litigation for which the only amounts sought relate to benefits within the normal terms of coverage under contracts of insurance issued by the company, and which are otherwise considered in the actuarial determination of the company's unpaid claim reserves.

10. Adequate provision has been made for adjustments and losses in collection of receivables.

11. Provision has been made for estimated retroactive adjustments by third-party payors under reimbursement agreements.

12. The Company is in compliance with bond indentures or other debt instruments.

13. Pending changes in the organizational structure, financing arrangements, or other matters that could have a material effect on the financial statements of the Company are properly disclosed.

14. The Company has properly classified all assets as admitted or nonadmitted in accordance with SSAP No. 4.

15. The Company has free and clear title to all owned assets, and there are no liens or encumbrances on such assets nor has any asset been pledged except as disclosed in the annual statement.

16. We have reviewed long-lived assets and certain identifiable intangibles whenever changes in circumstances have indicated that the carrying amount of these assets might not be recoverable and have recorded the adjustment in accordance with SSAP No. 5.

17. Deferred tax assets and liabilities as reported in the financial statements comply and have been valued in accordance with SSAP No. 10, Income Taxes.

18. Investments are appropriately recorded and valued as follows:

Bonds - are recorded and disclosed in accordance with SSAP No. 26 and interpretations thereof.

Short-term investments - are recorded and disclosed in accordance with SSAP No. 2 and interpretations thereof.

19. Accident and Health Premiums Due and Unpaid - Premiums are recognized and reported in accordance with SSAP No. 54. Uncollected premiums are reported in accordance with SSAP No. 6.

20. Adequate consideration has been given to, and appropriate provision made for, estimated adjustments to revenue, such as for denied claims and changes to diagnosis- related group (DRG) assignments.

21. All peer review organizations, fiscal intermediary, and third-party payor reports and information have been made available.

22. Cost Reports filed with third parties:

All required Medicare, Medicaid, and similar reports have been properly filed.

Management is responsible for accuracy and propriety of all cost records filed.

All costs reflected on such reports are appropriate and allowable under applicable reimbursement rules and regulations and are patient-related and properly allocated to applicable payors.

The reimbursement methodologies and principles employed are in accordance with applicable rules and regulations.

Adequate consideration has been given to, and appropriate provision made for, audit adjustments by intermediaries, third-party payors, or other regulatory agencies.

All items required to be disclosed, including disputed costs that are being claimed to establish a basis for subsequent appeal, have been fully disclosed in the cost report.

Recorded third-party settlements include differences between filed (and to be filed) cost reports and calculated settlements, which are necessary based on historical experience or new or ambiguous regulations that may be subject to differing interpretations.

23. The Company's actuary has certified to the propriety of the basis and amounts at which the claim reserves and all actuarial liabilities are stated at December 31, 2001.

24. The Company has recorded individual and group accident and health reserves in accordance with SSAP No. 54.

25. The Company's liabilities for unpaid claims and claim adjustment expenses are based on and recorded at management's best estimate in accordance with SSAP No. 55.

26. Utilization Data has been properly determined and included in the statutory financial statement.

27. Covered liabilities are properly stated in the statutory financial statement and are determined as health care services covered through "hold harmless" clauses in the provider contracts which

state that providers will not bill enrollees even though the provider has not been paid by the HMO.

28. The Company is in compliance with contractual agreements, grants, and donor restrictions.

29. There were no material commitments for construction or acquisition of property, plant and equipment, or to acquire other noncurrent assets, such as investments or intangibles.

30. Intentionally omitted.

31. We have complied with all aspects of contractual agreements that would have a material effect on the statutory financial statement in the event of noncompliance.

32. There are no material transactions that have not been properly recorded in the accounting records underlying the statutory financial statements.

33. All required returns and statutory reporting requirements have been filed on a timely basis with the appropriate regulatory bodies.

34. All material reinsurance transactions have been recorded and disclosed in accordance with SSAP No. 61.

35. The Company has properly disclosed and recorded all changes in accounting principles in accordance with SSAP No. 3.

36. The Company has recorded and disclosed subsequent events in accordance with SSAP No. 9.

37. Intentionally omitted.

38. The Company is not aware of the employment of or a business relationship with a "prohibited person" as defined in The Violent Crime Control and Law Enforcement Act of 1994: United States Code, Section 1033 (e)(1)(A).

39. Intentionally omitted.

40. Intentionally omitted.

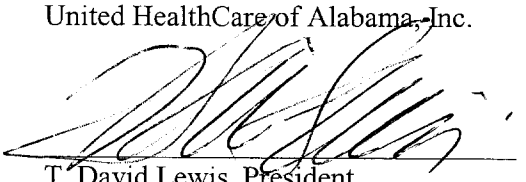
41. Intentionally omitted.

42. The Company has recorded and disclosed defined benefit plans and defined contribution plans in accordance with SSAP No. 8.

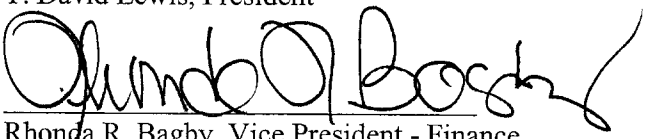
43. The Company has recorded and disclosed postretirement benefits other than pensions in accordance with SSAP No. 14.

We understand that your examination was made in accordance with standards established by the Alabama Department of Insurance, and procedures established by the *National Association of Insurance Commissioners*, and accordingly included such tests of the accounting records and such other procedures as considered necessary under the circumstances.

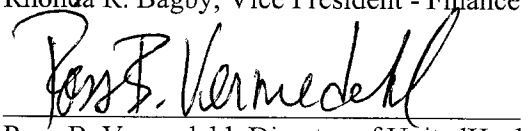
United HealthCare of Alabama, Inc.



T. David Lewis, President



Rhonda R. Bagby, Vice President - Finance



Ross B. Vermedahl, Director of UnitedHealthcare Finance

BOB RILEY
GOVERNOR

STATE OF ALABAMA
DEPARTMENT OF INSURANCE
201 MONROE STREET, SUITE 1700
POST OFFICE BOX 303351
MONTGOMERY, ALABAMA 36130-3351
TELEPHONE: (334) 269-3550
FACSIMILE: (334) 241-4192
INTERNET: www.aldoi.org

WALTER A. BELL
COMMISSIONER
DEPUTY COMMISSIONER
D. DAVID PARSONS
JAMES R. (JOHNNY) JOHNSON
CHIEF EXAMINER
RICHARD L. FORD
STATE FIRE MARSHAL
JOHN S. ROBISON
GENERAL COUNSEL
MICHAEL A. BOWNES
RECEIVER
DENISE B. AZAR
PRODUCER LICENSING MANAGER
JIMMY W. GUNN

September 9, 2003

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Mr. Jack A. Wickens
President
United Healthcare of Alabama, Inc.
3700 Colonnade Parkway
Birmingham, AL 35243

RE: Financial/Market Conduct Examination as of December 31, 2001

Dear Mr. Wickens:

Enclosed is a copy of the Report of Examination of the above-cited company as of December 31, 2001. In the event that you have any objections to this report, please advise this Department in writing within twenty (20) days, and a hearing will be scheduled, at which time you may present your arguments regarding any objections.

Unless we hear from you within the above-stated time, the report will be filed as a public document. Once filed, no annual or quarterly statements, or other material reflecting the statutory financial condition of the company may be filed with or accepted by this Department if those statements conflict with any basis of calculation to establish the value of any asset, liability, or capital account in the report.

Sincerely,

Richard L. Ford, CFE, CIE
Chief Examiner

RLF:dk
Enclosure
cc: Jack M. Brown, CFE, CIE
Jim Hattaway, CFE
LaShonda Moultrie
Taylor-Walker and Associates, Inc.